UNITED STATES OF AMERICA v. OMAR AHMED KHADR	**Defense Motion** **For Appropriate Relief** Appointment of Requested Defense Expert Consultants and Witnesses Brigadier General [redacted] in the Field of Developmental Psychiatry and Dr. Katherine Porterfield in the Field of Clinical Psychology 11 June 2008

1. **Timeliness:** This motion is filed within the timeframe established by the Military Commission Trial Judiciary Rules of Court.

2. **Relief Sought:** The defense respectfully requests that this Commission order the appointment of (1) [redacted], M.D. (Ret'd) to work as an expert consultant and witness with the defense in the field of developmental psychiatry, and (2) Dr. [redacted] to work as an expert consultant and witness with the defense in the field of clinical psychology.

3. **Burdens of Proof & Persuasion:** The Defense bears the burden of establishing that it is entitled to the requested relief. R.M.C. 905(c)(2)(A). "[T]he burden of proof on any factual issue the resolution of which is necessary to decide a motion shall be by a preponderance of the evidence." R.M.C. 905(c)(2).

4. **Facts:**

a. On 2 May 2008, the defense requested the Convening Authority to appoint Drs. Katherine Porterfield and Gen. [redacted] as expert consultants for the defense. Dr. Porterfield is a developmental psychologist who also has expertise in trauma and torture. *See* Defense Request for Appointment of Expert Consultant [redacted] to the Defense Team, dated 2 May 2008 (attachment A). [redacted]s is a child and adolescent psychiatrist. *See* Defense Request for Appointment of Expert Consultant Brigadier General [redacted], M.D. (Ret.) to the Defense Team, dated 2 May 2008 (attachment B).[1]

b. The convening authority denied the request for both Drs. [redacted] on 20 May 2008. (Memorandum from Convening Authority, 20 May 08 [hereinafter CA's Denial] (attachment C).)[2]

c. The requests were made after consultation with numerous juvenile justice and mental health experts who instructed the defense team that the kind of mental health evaluation

[1] The classified version of these requests will be filed with the Commission in Guantanamo Bay.

[2] The classified version of the request will be filed with the Commission in Guantanamo Bay.

requested was standard for all juvenile cases involving violence, and that a failure to conduct the necessary evaluations would be tantamount to legal malpractice.[3]

d. The facts surrounding Mr. Khadr's upbringing, capture and detention make this evaluation all the more relevant and critical to the preparation of a defense and, if necessary, evidence on sentencing.

i. Mr. Khadr was raised in an austere religious environment, was forced by his family to travel frequently between his native Canada and the developing world, was withdrawn from public school no later than the age of ten and ultimately transported to live in a secluded religious community in the rural regions of Afghanistan during a civil-war in that country. Michelle Shephard, GUANTANAMO'S CHILD 61 (Wiley 2008) ("GUANTANAMO'S CHILD"). At the age of fifteen, he was separated from his family after his father gave him away to a known Islamic militant, Abu Laith al-Libi, who maintained an independent militia, the Libyan Islamic Fighting Group ("LIFG"), in Afghanistan during the U.S. invasion in 2001-2002. *Id*. at 82; *See* Evan F. Kohlmann and Josh Lefkowitz, *Dossier: Libyan Islamic Fighting Group*, Oct. 2007 (Attachment A to D-044); Aljazeera.net report, 3 Nov 07*available at* http://english.aljazeera.net/NR/exeres/1BA708B9-39ED-4B51-BED9-9B5322E75A8E.htm (Attachment B to D-044). Mr. Khadr was abandoned by Abu Laith to the company of a group of unknown fighters, presumably members of Abu Laith's LIFG, who were preparing to engage in combat operations ("LIFG fighters"). Shephard at 83.

ii. Mr. Khadr was kept inside the compound during an extensive firefight between the LIFG fighters and U.S forces outside. (After Action Report, 27 Jul 02 (attachment A to D028, Def. Mot. Depose LtCol W).) The U.S. forces then requested air support, which pummeled the compound with cannon fire, rockets, and bombs from fixed-wing planes and helicopters over the course of two to three hours. *Id.* at 00766-000586. "The pounding to the compound was relentless, with many sections of exterior wall collapsing. A fire started inside the compound in one of the buildings." *Id*. The volume of fire was so intense that "[i]t was believed by [the U.S. forces] that there was no way that anyone had survived the guns, rockets and bombs . . . ." *Id.*

iii. In addition to the concussive force of the bombardment, Mr. Khadr sustained shrapnel and gunfire wounds to the head and body, including shrapnel wounds to the eyes. Radiologic Examination Report, 18 Jul 07 (attachment D); (Khadr Affidavit, ¶ 3, 25 (attachment E).) These wounds left him temporarily blind and resulted in permanent vision loss in his left eye and diminished vision in his right. *See* Medical Record of 28 Oct 02 (attachment F). While blinded and either sitting or kneeling against a wall with the action behind him, he was then shot at least twice in the back. (OC-1 Statement, 17 Mar Jul 04 (attachment B to D022, Def. Reply Mot. Dismiss Due to Lack of Jurisdiction Under the MCA in Regard to Juvenile Crimes of a Child Soldier). According to eye-witness accounts, he remained conscious as CPT Martinko gave an order to PV2 Reep to execute him, while he lay wounded and prostrate.

[3] The defense is in the process of obtaining affidavits from several of the experts who so advised the defense and will file them with the Commission when they are available.

(Officer Diary at 00766-001380 (attachment G to D028, Def. Mot. to Depose LtCol W.) Only after the intervention of a Special Forces soldier was his life spared. (*Id*.)

iv. Mr. Khadr was then transported to Bagram Airbase, where he was secured to a stretcher and interrogated from the moment he regained consciousness a week later. (Khadr Affidavit, ¶ 7.) If the interrogators did not like the answers he gave, they shackled his hands and feet to the stretcher stretching his badly wounded chest and causing him great pain. (*Id.*) Although he did not have the physical strength to stand due to his injuries, interrogators would force him to sit up in the stretcher to cause pain. (Khadr Affdiavit, ¶ 20.) He was held with adult detainees, routinely abused and subject to, at a minimum, cruel, inhuman and degrading treatment and called by the nickname "buck-shot" due to the shrapnel injuries all over his body. GUANTANAMO'S CHILD at 90. At one point, interrogators pulled him off his stretcher, causing him to fall and cut his left knee. (Khadr Affidavit, ¶ 17.) With a hood wrapped so tightly around his neck that it nearly chocked Mr. Khadr and made it difficult to breath, barking dogs were brought to the interrogation room on several occasions, terrifying him. (Khadr Affidavit, ¶ 18.) He had cold water thrown on him. (*Id*.)

v. Once Mr. Khadr was finally mobile, he was forced to carry five-gallon buckets of water and lift and stack heavy crates of bottled water despite the healing shrapnel and bullet wounds to his shoulders and back. (Khadr Affidavit, ¶ 22.) He was also was forced to clean the floors on his hands and knees in the middle of the night. (Khadr Affidavit, ¶ 21.) In Bagram, Mr. Khadr's hands were chained, and sometimes tied, above his head above his head to the doorframe or ceiling of the cell, stretching his healing chest wounds. (Khadr Affidavit, ¶¶ 19, 31.) This occurred during in Bagram, which was during the first three months of Mr. Khadr's captivity. Mr. Khadr's chest wounds were infected, swollen, and still seeping blood nearly seven months after the firefight, and Mr. Khadr was in the hospital receiving treatment for the gunshot wounds ten months after the firefight.[4]

vi. His captors took advantage of his eye wounds by shining extremely bright lights "right up against" his face, causing his eyes to tear incessantly and causing tremendous pain. (Khadr Affidavit, ¶ 25.) This may have contributed to the permanent blindness he now endures. The reports of his interrogations show the consistent use of the "fear up" technique in the very first weeks following his capture, which at times included threats of homosexual rape. (*See, e.g.*, Interrogator Notes, 14 Aug 02, 00766-001189 (attachment G); Interrogator Notes, 16

[4] *See* Report of Investigative Activity of 3 June 03 at 1, 00766-000154 (Khadr was interrogated during a June 2003 hospitalization due to infections to his gunshot wounds and hospitalization was expected to last six more weeks) (attachment L to D027); Report of Investigative Activity of 12 Mar 2003 at 1, 00766-000151 (attachment M to D027) (Khadr was scheduled to have surgery on his chest wounds on 13 Mar 2003); Report of Investigative Activity of 20 Feb 03 at 1, 00766-000146 (attachment N to D027) (Khadr's wounds swelled to the point of bursting); Report of Investigative Activity of 17 Feb 03 at 2, 00766-000145 (attachment O to D027) (blood was seeping from Khadr's wounds); Report of Investigative Activity of 6 Jan 2003 at 2, Bates No. 00766-000140 (attachment P to D027) (Khadr complained to interrogators of pain from his chest and shoulder injuries).

Aug 02, Bates No. 00766-001193 (attachment H); Interrogator Notes, 17 Aug 02, Bates No. 00766-001195 (attachment I); Khadr Affidavit, ¶¶ 23, 55, 56.)

vii. At barely sixteen years old, Mr. Khadr was transferred to GTMO, which entailed being starved of food for two nights and one day prior to transfer. His head and face were shaved. A mask was placed over his mouth and nose and goggles and earphones to induce prolonged sensory-depravation. On the plane, Mr. Khadr was shackled to the floor for the entire trip and physically abused if he moved. (Khadr Affidavit, ¶ 32.)

viii. Upon his arrival, and without explanation, he was stripped naked and subjected to a manual search of his anus. (Khadr Affidavit, ¶ 34.) He was then repeatedly pinned against a wall by two soldiers, unable to breathe, until he passed out. (Khadr Affidavit, ¶ 36.)

ix. Mr. Khadr was interrogated immediately upon arrival. He was then placed in a small cell with walls and a small window that he could not look out of. He had no human contact. He was moved in and out of isolation and to different cells depending on how he answered during successive interrogations. (Khadr Affidavit, ¶¶ 40, 41.) When not in solitary confinement, Mr. Khadr was held with adult detainees. All of the detainees that lived in the same cellblock as Mr. Khadr were much older than he was and Arab. Because of the age and cultural differences, these detainees were very hostile towards Mr. Khadr and would often yell at him. *See* Form 302, 3 Feb 03, Bates No. 00766-000047-48 (attachment J); Form 302, 17 Feb 03, Bates No 00766-000049-50 (attachment K); RIA, 17 Feb 03, Bates No. 00766-000144-45 (attachment L). During some of Mr. Khadr's interrogations, he was put in painful positions and his hands and feet were shackled to a bolt in the floor for hours at a time in – on one occasion five or six hours. (Khadr Affidavit, ¶¶ 50, 54.)

x. Because of very harsh detention conditions and interrogation methods, Mr. Khadr often succumbed to bouts of depression and collapsed crying during interrogations. *See, e.g.*, Form 302 of 16 Jan 03, Bates No. 00766-000046 (attachment M) ("KHADR did not respond to interviewers. He put his head down and cried. KHADR appeared suicidal and depressed."); Report of Investigative Activity (RIA), 24 Feb 03, Bates No. 00766-000150 (attachment N) (summarizing interrogations on 14 Feb 03 where Mr. Khadr was extremely despondent and "cried heavily").

xi. Mr. Khadr was visited on numerous occasions by individuals claiming to be from the Canadian government. These included four visits over four days starting on February 13, 2003. RIA, 24 Feb 03, Bates No. 00766-000148-50 (attachment O) (summarizing interrogations with Canadians from 13-16 Feb 03). During these visits, the Canadians asked him a lot of questions but offered him no assistance. When Mr. Khadr informed these Canadians that he had lied and told the Americans whatever they wanted to hear because he had been tortured, they yelled at him and called him a liar. (Khadr Affidavit, ¶¶ 43-49.)

xii. In the early spring of 2003, Khadr was told "Your life is in my hands" by a military interrogator, who spat on him, tore out some of his hair and threatened to send him to a country like Jordon, Syria or Egypt, where he would be tortured. He was then again threatened with homosexual rape. The interrogator shackled Mr. Khadr's hands and ankles together and

made him sit on the floor. The interrogator ordered him to stand up, which was difficult to do because of the shackles. After Mr. Khadr managed to stand, the interrogator ordered him to sit down again and then get back to his feet. When Mr. Khadr could not stand, the interrogator called in two military police officers who lifted him up and then dropped him to the floor. They did this five times at the instruction of the interrogator. At the end of the meeting, the interrogator told Mr. Khadr that the Americans would throw his case in a safe and that he would never leave Guantanamo. (Khadr Affidavit, ¶¶ 56, 57.)

xiii. Just before Ramadan in 2003, following another interrogation by Canadian officials, everything was taken away from him except for a mattress. He spent a month in isolation. The room in which he was confined was kept very cold. Mr. Khadr said that it was "like a refrigerator." (Khadr Affidavit, ¶ 53.)

ivx. During one interrogation in November 2003, Mr. Khadr was taken to an interrogation room between midnight and 0100. The interrogator there told him that his brother was at Guantanamo and that he should "get ready for a miserable life." When Mr. Khadr asked to see his brother, the interrogator became angry and called in the military police. The police cuffed Mr. Khadr to the floor with his arms in front of his legs for a half hour, behind his legs for another half hour, and then forced him onto his knees and cuffed his hands behind his legs. Later still, the police forced him onto his stomach, bent his knees, and cuffed his hands and feet together. At some point, Mr. Khadr urinated on himself and the floor. The police poured pine oil on him and the floor, and then dragged Mr. Khadr through the mixture of oil and urine while he was lying on his stomach with his hands and feet cuffed together. Later, he was returned to his cell and was not given a change of clothes for two days. (Khadr Affidavit, ¶ 59.)

vx. Several of Mr. Khadr's allegations regarding his treatment have been corroborated by government documents and government personnel. For example, Major B., the CJTF 180 Staff Liaison to the ICRC in Bagram during late 2002, has explained the ICRC complaints regarding confinement conditions in Bagram included complaints relating to the use of handcuffs and hooding, "safety positions", "punishment", and chaining and forced standing. (Sworn Statement of Major B. at 3, 5, Bates no. 00766-004528, 4530 (attachment C to D058, Def MTC (ICRC Documents).) One of the ICRC's specific complaints was that that "a detainee was kept chained to the ceiling for over a day." (*Id*. at 4, Bates no. 00766-004529.) And during a visit, the ICRC observed a detainee being punished for falling asleep on the toilet by cuffing his hands and chaining him in the airlock (*id*.), which is the treatment Mr. Khadr described in paragraphs 19 and 31 of his affidavit. Also, a former Bagram MP, interviewed by CID agents in the course of a nominal "investigation" into allegations of abuse lodged by Mr. Khadr after he was first provided with access to counsel, confirms that forced standing was a standard military intelligence procedure at Bagram, and that detainees were made to clean floors and perform similar tasks as described by Mr. Khadr. (Sworn Statement of Sgt P, Def Req to Supp D-048.) And Bagram personnel familiar with the habits of Mr. Khadr's principal interrogator, Sgt C, show that Sgt C was among the most aggressive and abusive of interrogators at Bagram at the time Mr. Khadr was detained there. (Sworn Statement of Sgt [redacted], Def Req to Supp D-048 (noting Sgt C's excessive use of the "fear up" technique).) Sgt C was ultimately court-martialed for his role in the death of a Bagram detainee who died in U.S.

custody. (*See* Dept of the Army Report of Results of Trial ICO *United States v. [C]* (attachment A to D-027).)[5]

5. Argument:

a. Statutory Provision For Expert Witnesses

The MCA and the Manual for Military Commissions authorize the employment of experts to assist the parties in both the development and presentation of their cases. R.M.C. 703(d). In order to employ an expert at Government expense, a party must submit a request to the convening authority to authorize and to fix the compensation for the expert. A request denied by the convening authority may be reviewed by the military judge, who shall determine whether the testimony of the expert is relevant and necessary. R.M.C. 703(d).

b. Standard For Authorization Of Defense Experts

i. Rule for Military Commission (R.M.C.) 703(d) requires the moving party to show that the expert is relevant and necessary. This standard is identical to the standard for the employment of experts set forth in the Manual for Courts-Martial. *Compare* R.M.C. 703(d) *with* R.C.M. 703(d).

ii. "Relevance" is defined by the M.C.R.E. as having "probative value to a reasonable person," which means that "when a reasonable person would regard the evidence as making the existence of any fact that is of consequence to a determination of the commission action more probable or less probable than it would be without the evidence." M.C.R.E. 401.

iii. An expert is deemed necessary when the defendant shows that there is more than a "mere possibility" of assistance from a requested expert. *United States v. Robinson*, 39 M.J. 88, 89 (C.M.R. 1994); *United States v. Kinsler*, 24 M.J. 855, 856 (A.C.M.R. 1987). The defense must show that there is a reasonable probability both that the expert would be of assistance to the defense and that the denial of expert assistance would result in a fundamentally unfair trial. *Id.*

iv. Once the defense has made a showing that the expert is both relevant and necessary, the Government must either provide the expert or an adequate substitute. *United States v. Tornowski*, 29 M.J. 578, 580-81 (A.F.C.M.R. 1989). Where the Government seeks a substitute, that person must possess similar professional qualifications as the requested witness. *United States v. Robinson*, 24 M.J. 649 (N.M.C.M.R. 1987); *United States v. Tone*, 28 M.J. 1059 (N.M.C.M.R. 1989). Under some circumstances, independent experts cannot be replaced by government experts. *United States v. Burnette*, 29 M.J. 473 (C.M.A. 1990) (noting that government-appointed consultant was not an adequate substitute for the independent assistance that the expert requested by the defense would have provided).

[5] The defense expects to offer classified attachments in support of additional allegations contained in Mr. Khadr's affidavit.

c. The Assistance Of Expert Mental Health Consultants Sought By The Defense Is Relevant

i. As is detailed in the requests to the Convening Authority, BG [redacted] and Dr. [redacted] must conduct a comprehensive mental health evaluation of Mr. Khadr in order to determine, principally, what effect his lengthy confinement and treatment has had on his ability to accurately recall the events leading up to his capture and participate competently in his defense.

A. Mr. Khadr was fifteen years old at the time of the battle in which he was captured and has since that time been held in continual detention with adult detainees, often kept in solitary confinement, and provided no accommodation for his age. Mr. Khadr has only recently been transferred to Camp IV at defense counsel's request. He has therefore only been permitted communal meals, prayer and regular contact with other detainees for the past eleven months. Accordingly, Mr. Khadr has spent most of the past six years either in communal cells (as a juvenile) with adults or walled off entirely from human contact and subject to objectively harsh conditions of confinement. Mental health experts would find that such treatment and conditions could seriously affect legal determinations relating to Mr. Khadr's competence and memory as well as issues relating to substantive defenses and sentencing.

B. On advice from juvenile mental health and juvenile justice experts, his defense counsel were informed that in murder cases, both a clinical psychologist and a psychiatrist are routine and necessary to evaluate the individual's fitness to stand trial. Counsel have observed potential symptoms of disorders in cognitive development that could be impairing his ability to assist in his defense. In 2005, psychiatrists and psychologists who reviewed the nature and frequency of those observed behaviors and who reviewed a Proxy Psychiatric Examination administered by counsel, found significant indications that Mr. Khadr suffers from Post-Traumatic Stress Disorder and Major Depressive Episodes. Such conditions could seriously affect legal determinations relating to Mr. Khadr's competence and memory as well as issues relating to substantive defenses and sentencing. *See* Proxy Psychiatric Assessment, dated 13 Apr 05 (attachment P); Letter of Dr. Daryl Matthews, dated 21 Apr 05 (attachment Q); Declaration of Dr. Eric W. Trupin, dated 17 Mar 05 (attachment R).

C. As detailed above, Mr. Khadr was subject to threats to his physical safety, assaults and serial coercive interrogations that, at a minimum, constituted cruel, inhuman and degrading treatment. This treatment continues to impact his mental health and has proven to be a persistent obstacle in consulting with him and in preparing his defense. These are not "speculations" but practical difficulties his defense counsel has both experienced and observed.

D. For example, when asked about the events underlying his case and his treatment over the past six years, Mr. Khadr has frequently expressed reluctance to discuss the details of his treatment and interrogation and even compared defense counsel with his interrogators. There is therefore a profound mistrust of his U.S. attorneys rooted in his treatment at the hands of interrogators. To the extent this behavior is the product of an underlying mental condition, Mr. Khadr may well be unfit to stand trial.

E. Given Mr. Khadr's age and the length of his confinement, common sense dictates that these conditions had a very high probability of negatively influencing his cognitive development. Whether this is so and whether their degree is so significant that they will impair his ability to stand trial is something that only mental health experts can establish.

ii. An independent mental health assessment is relevant to evaluating the extent to which his interrogations, questioning and confinement have had any improper or unduly suggestive influences on any statements he has made since his capture.

A. The prosecution is planning on building most of its case around the reports of statements Mr. Khadr is alleged to have made when he was younger than eighteen years of age, and in most instances still recovering from recent and critical combat wounds. The findings and possible testimony of BG [redacted] are directly relevant and necessary to challenge the Government's evidence. In *United States v. Van Horn*, 26 M.J. 434, 438 (C.M.A. 1988), the Court of Military Appeals held that where the government proffers an interpretation of certain evidence as the only basis for a finding of guilt, to deny the defense a meaningful opportunity to challenge the reliability of the government's interpretation denies the defendant a fair trial. In *Van Horn*, the government built its case upon a urinalysis showing the presence of cocaine. The Court of Military Appeals held that it was reversible error for the defendant to be deprived of an expert witness, who could testify as to the unreliability of the particular method of urinalysis used to demonstrate guilt. Mr. Khadr's alleged "confessions" to interrogators are not transcribed, the vast majority are not supported by interrogator notes, and the statements would be clearly inadmissible in either a court-martial or a federal court. *See, e.g.*, *Miranda v. Arizona*, 384 U.S. 436 (1966); M.R.E. 802. At a minimum, introduction of such statements as evidence presents a novel method of truth-finding in criminal proceedings and the defense must have as much of an opportunity as the defendant in *Van Horn* did in contesting whether the urinalysis was adequate to proving guilt.

B. In order for the defense to make informed arguments about the admissibility and weight of such statements, the defense must be allowed to present expert testimony on the psychological impact of war trauma and interrogation on juveniles.[6] In the absence of such expert assistance and testimony, the military judge will be unequipped to judge the admissibility of these statements and the military commission will be unable to evaluate adequately the weight such statements should be afforded.

C. Evaluations and testimony by mental health experts as to the depth and duration of torture, coercion and the number of times and length of interrogations – and their

[6] The United States Supreme Court has held that a defendant was denied his 6th and 14th Amendment right to present a defense where he was precluded from presenting evidence about the environment in which a confession was obtained. *Crane v. Kentucky*, 476 U.S. 683, 688-91 (1986). The Court held that if the jury cannot hear such evidence, "the defendant is effectively disabled from answering the one question every rational juror needs answered: If the defendant is innocent, why did he previously admit his guilt?" *Id*. at 689. The *Crane* court pointed out that this issue is entirely independent from the issue of the confession's voluntariness and that the Due Process Clause and the Confrontation Clause of the Sixth Amendment entitle a criminal defendant to "'a meaningful opportunity to present a complete defense.'" *Id*. at 690.

effects on an adolescent – is critical to the determination of the admissibility of any statements made by the defendant.

iii. This testimony is further relevant and necessary because mental state at the time of the crime is an affirmative defense that cannot be asserted without an independent mental health assessment.

A. "It is an affirmative defense to any offense that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his or her acts." R.M.C. 916(k)(1); s*ee also* MCA § 949k.

B. Without evaluations by mental health experts who understand child and adolescent development as well as the emotional and behavioral effects of trauma, threat or coercion by adults, the defense would be prohibited from exploring the defendant's mental state and his criminal intent, or lack thereof, at the time he allegedly committed these crimes.

C. Moreover, the advice of juvenile health experts is necessary to determining what likely effects the blast overpressure would have had on Mr. Khadr following his substantial exposure to munitions fire during the 27 July 2002 battle.

1. According to LtCol W., the compound in which Mr. Khadr was being held was strafed by four F/A-18s, "until dry," firing over 2000 rounds of 20mm cannon fire into the compound. The F/A-18s then switched to rockets. "After several runs," the four F/A-18s exhausted their rocket rounds. Two of the four F/A-18s dropped MK-82, 500 lb warhead, bombs with "pinpoint accuracy, both landing inside the compound." Memorandum for Commander, dated 28 July 2002, at paras. 2(c), 2(G) (attachment B to D028, Def. Mot. to Depose LtCol W.); *but see* After Action Report, 27 Jul 02 at 00766-000586 (attachment A to D028) (describing four MK-82s being dropped, three on target, one going long).

2. Four Apache helicopters followed suit, directing at least 150 rounds of 30mm cannon fire and 62 Hydra 70 FFAR rockets into the compound. After expending all of their available rounds, the Apache helicopters were followed by a pair of A-10s, who "expended all of their rockets and gun rounds." This comprised at least 1500 rounds of 30mm cannon fire and 12 Hydra 70mm rockets. Memorandum for Commander, dated 28 July 2002, at paras. 2(c), 2(G) (attachment B to D028).

3. One 40mm round from an MK-19 grenade launcher was fired into the compound. Memorandum for Commander, dated 28 July 2002, at paras. 2(c), 2(G). Other witness statements discuss U.S. forces tossing hand grenades around the compound as U.S. forces entered the compound. *See*, *e.g.*, RIA, 5 Dec 05, Summary of SSG D.E.L. Interview, Bates No. 00766-001284-86 (attachment S); RIA, 5 Dec 05, Summary of SSG J.M.L. Interview, Bates No. 00766-001242-44 (attachment T).

4. The concussive effect of these munitions, let alone the shrapnel injuries suffered by Mr. Khadr, cast considerable doubt on his ability to behave volitionally, let alone rationally. Academic literature describes the common neurological

consequences of considerably less blast overpressure than Mr. Khadr would have experienced as "pain, altered consciousness, cognitive impairment, loss of function, and epilepsy." *See* Michael F. Finkel, *The neurological consequences of explosives,* Journal of the Neurological Sciences 249 (2006) 63–67 (attachment U).

5. The physical impact this would have had on him is critical to the formulation and presentation of defenses such as lack of mental responsibility. An element of the offense of Charge I, Murder in Violation of the Law of War, is that the accused "intended to kill the person or persons." M.M.C., Part IV, ¶ 15(b)(4). If Mr. Khadr was suffering from "altered consciousness," "cognitive impairment," or "loss of function," then he could not have had the requisite *mens rea* to be guilty of the charge.

d. The Assistance Of Expert Mental Health Consultants Sought By The Defense Is Necessary

i. A complete physical and mental health examination must be conducted in order to determine if Mr. Khadr has any physical or cognitive disorder or any syndrome that could impair his mental capacities, especially as they relate to his memory and understanding of the events around him.

ii. Such symptoms are usually associated with one or more traumatic events. His treatment by his parents, the events leading up to the battle, the battle itself, his own injuries, his subsequent confinement, his learning of the death of his father and the serious crippling of his younger brother are all examples of traumatic events that could have contributed to a mental disorder, condition or syndrome. Additionally, Mr. Khadr was seriously wounded in July 2002, shrapnel remains in his head and body, he has lost the vision of his left eye, has poor vision in his right eye and endures a variety of other physical ailments that could result in cognitive impairment.

iii. It is also necessary for a psychiatrist with expertise in adolescent development to assess what Mr. Khadr's level of cognitive development, awareness of his circumstances and capacity for independent thought and action would have been at the age when he was wounded, captured and alleged to have freely engaged in criminal conduct.

iv. The Convening Authority dismissed these asserted defense needs as merely "speculation of possible assistance". (CA's Denial at 2.)

A. What the Convening Authority ignores, however, is that the very fact that Mr. Khadr was a juvenile at the time of these events casts his mental state into doubt. Indeed it was fifteen-year-olds' lack of capacity, "their inherent difference from adults in their capacity as agents, as choosers, as shapers of their own lives," that made their crimes, even heinous crimes perpetrated in civilian life, undeserving of the death penalty. *Thompson v. Oklahoma*, 487 U.S. 815, n.23 (1988).

B. Moreover, the administrators of JTF-GTMO were conscious of the needs of juvenile detainees during the lion's share of Mr. Khadr's incarceration. The consensus recommendation submitted by the JTF Surgeon, [redacted], expressly noted "Exposure of pediatric detainees to adult detainees will have a high likelihood of producing physical,

emotional, and psychological damage to the pediatric detainee." Recommended Course of Action for Reception and Detention of Individuals Under 18 Years of Age, dated 14 Jan 03 at 1 ("RCA") (attachment D to D062).

C. All other juvenile detainees, with the notable exception of Mr. Khadr and Mohammad Jawad, whose age until recently was unknown, were treated separately in Camp Iguana and treated consistently with the RCA. Instead, Mr. Khadr was held without any consideration of his age or special vulnerability. [redacted]. *See* Classified Defense Request for Appointment of Expert Consultant Dr. Katherine Porterfield to the Defense Team, para. 4(a)(iii) and documents cited therein; Classified Defense Request for Appointment of Expert Consultant Brigadier General [redacted] to the Defense Team, para. 4(a)(iii) and documents cited therein. The Convening Authority describes this report as merely a statement of how well Mr. Khadr was [redacted]. (*See* Classified CA Denial.) The Defense contends that it is perverse and shameful for the United States government to describe the contemplation of [redacted] by a sixteen year old boy, who suffered months of abuse, violence and danger as [redacted]. (*Id*.) Despite the government's repeated attempt to portray Mr. Khadr as a sub-human terrorist, who happily volunteered to fight to the death, all the available evidence indicates Mr. Khadr was a scared fifteen year old boy, who was affected just as any other similarly situated teenager would be and who acted just as any other similarly situated teenager would act.[7]

v. When the defendant's mental capacity at the "time of the offense is to be a significant factor at trial, the State must, at a minimum, assure the defendant access to a competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation, and presentation of the defense." *Ake v. Oklahoma*, 470 U.S. 68, 83 (1985); *United States v. Mann*, 30 M.J. 639 (N.M.C.M.R. 1990). Indeed, counsel's failure to conduct a comprehensive mental health evaluation in a juvenile murder case such as Mr. Khadr's constitutes professional misconduct and will ultimately be reversible error as "contrary to professional norms of competent assistance." *Burger v. Kemp*, 483 U.S. 776, 813 (1987).

vi. The accused is entitled to have access to a qualified psychiatrist and psychologist for presenting an insanity or mental capability defense. *United States v. Mustafa*, 22 M.J. 165, 169 (C.M.A. 1986); *see also United States v. Kelly*, 39 M.J. 235, 237 (C.M.A. 1994) (quoting *Ake v. Oklahoma*, 420 U.S. 68 (1985)). Consequently, where, as here, the mental state of the accused at the time of the alleged crime is in question, the defense must have access to a qualified psychiatric expert to adequately present a defense.

vii. Finally, the request for the services of both BG [redacted], a developmental psychiatrist, and Dr. [redacted], a clinical psychologist specialized in juvenile development and trauma, is necessary to conduct a comprehensive mental health assessment of Mr. Khadr.

[7] The redacted portions of this paragraph contain classified information. A classified version of this motion will be filed in Guantanamo Bay.

A. Juvenile mental health and juvenile justice experts informed defense counsel that in murder cases both a clinical psychologist and a psychiatrist are routine and necessary to evaluate the individual's fitness to stand trial.

B. A clinical psychologist, such as Dr. [redacted], is qualified to administer and interpret neuropsychological tests, such as intelligence, personality, and neuropsychological function tests as well as projective testing that could reveal any thought disorder. These tests can only be performed by a clinical psychologist and are necessary to the kind of comprehensive psychiatric assessment that is required to rule out the kind of brain damage or personality disorder that would be difficult or impossible to detect by counsel or even a trained psychiatrist.

C. A developmental psychiatrist, such as Dr. [redacted] must integrate the neuropsychological findings provided by Dr. [redacted] with Mr. Khadr's family, medical and mental health history. Dr. [redacted] is uniquely qualified as a psychiatrist to incorporate his evaluation of Mr. Khadr's physical and mental health, including a mental status examination, into a complete diagnosis that must serve to rule out any potential brain damage or neurological disorder.

D. The likelihood of brain damage for someone such as Mr. Khadr is considerable given the blunt trauma to the head he suffered and the age at which he suffered it. These unresolved questions go directly to his competence to stand trial, provide evidence, understand the nature and gravity of court proceedings and otherwise cooperate in his defense. With a comprehensive evaluation, defense counsel cannot competently represent Mr. Khadr and would be subject to potential liability for failing to do so.

6. Oral Argument: The Defense requests oral argument as it is entitled to pursuant to R.M.C. 905(h), which provides that "Upon request, either party is entitled to an R.M.C. 803 session to present oral argument or have evidentiary hearing concerning the disposition of written motions." Oral argument will allow for thorough consideration of the issues raised by this motion.

7. Witnesses & Evidence: The defense does not anticipate the need to call witnesses in connection with this motion. The defense relies on the following documents as evidence in support of this motion:

Attachments A-U

Evan F. Kohlmann and Josh Lefkowitz, *Dossier: Libyan Islamic Fighting Group,* Oct. 2007 (Attachment A to D-044)

Aljazeera.net report, 3 Nov 07*available at* http://english.aljazeera.net/NR/exeres/1BA708B9-39ED-4B51-BED9-9B5322E75A8E.htm (Attachment B to D-044).

After Action Report, 27 Jul 02 (attachment A to D028)

OC-1 Statement, 17 Mar Jul 04 (attachment B to D022)

Officer Diary, Bates No. 00766-001380 (attachment G to D028)

Report of Investigative Activity, 3 June 2003, Bates No. 00766-000154 (attachment L to D027)

Report of Investigative Activity, 12 March 2003, Bates No. 00766-000151 (attachment M to D027)

Report of Investigative Activity, 20 February 2003, Bates No. 00766-000146 (attachment N to D027)

Report of Investigative Activity, 17 February 2003, Bates No. 00766-000145 (attachment O to D027)

Report of Investigative Activity, 6 Jan 2003, Bates No. 00766-000140 (attachment P to D027)

Sworn Statement of Major B., (attachment C to D058)

Memorandum for Commander, 28 July 2002, (attachment B to D028)

Recommended Course of Action for Reception and Detention of Individuals Under 18 Years of Age, dated 14 January 2003 (attachment D to D062)

8. **Conference:** The Defense has conferred with the Prosecution regarding the requested relief. The Prosecution objects to the requested relief.

9. **Additional Information:** In making this motion, or any other motion, Mr. Khadr does not waive any of his objections to the jurisdiction, legitimacy, and/or authority of this Military Commission to charge him, try him, and/or adjudicate any aspect of his conduct or detention. Nor does he waive his rights to pursue any and all of his rights and remedies in and all appropriate forms.

10. **Attachments:**

A. Defense Request for Appointment of Expert Consultant Dr. [redacted] to the Defense Team, 2 May 2008

B. Defense Request for Appointment of Expert Consultant Brigadier General [redacted] M.D. (Ret.) to the Defense Team, 2 May 2008

C. Memorandum from Convening Authority, 20 May 2008

D. Radiologic Examination Report, 18 Jul 07

E. Khadr Affidavit, 22 February 2008

F. Medical Record of 28 October 02

G. Excerpt from Interrogator Notes, 14 August 02, 00766-001189

H. Excerpt from Interrogator Notes, 16 August 02, Bates No. 00766-001193

I. Excerpt from Interrogator Notes, 17 August 02, Bates No. 00766-001195

J. Form 302, 3 February 2003, Bates No. 00766-000047-48

K. Form 302, 17 February 2003, Bates No 00766-000049-50

L. Record of Investigative Activity, 17 February 2003, Bates No. 00766-000144-45

M. Form 302, 16 January 2003, Bates No. 00766-000046

N. Record of Investigative Activity, 24 February 2003, Bates No. 00766-000150

O. Record of Investigative Activity, 24 February 2003, Bates No. 00766-000148-50

P. Proxy Psychiatric Assessment, dated 13 April 2005

Q. Letter of Dr. [redacted], dated 21 April 2005

R. Declaration of Dr. [redacted], dated 17 March 2005

S. Record of Investigative Activity, 5 December 2005, Summary of SSG D.E.L. Interview, Bates No. 00766-001284-86

T. Record of Investigative Activity, 5 December 2005, Summary of SSG J.M.L. Interview, Bates No. 00766-001242-44

U. Michael F. Finkel, *The neurological consequences of explosives*, Journal of the Neurological Sciences 249 (2006)

Rebecca S. Snyder

William Kuebler
LCDR, USN
Detailed Defense Counsel

Rebecca S. Snyder
Assistant Detailed Defense Counsel

DEPARTMENT OF DEFENSE
OFFICE OF THE CHIEF DEFENSE COUNSEL
OFFICE OF MILITARY COMMISSIONS

2 May 2008

MEMORANDUM FOR THE CONVENING AUTHORITY

Subj: *UNITED STATES V. KHADR* - REQUEST FOR APPOINTMENT OF EXPERT CONSULTANT BRIGADIER GENERAL [redacted], M.D. (RET'D), TO THE DEFENSE TEAM

Encl: (1) Curriculum Vitae of Dr. [redacted]
(2) MC Form 13-1

1. The defense in United States v. Omar Khadr requests the Convening Authority approve BG [redacted], M.D. (Ret'd), as an expert consultant in the field of Developmental Psychiatry.

2. Qualifications: Dr. [redacted] is a clinical psychiatrist and an expert in the area of child and adolescent psychiatry. He is board certified in general psychiatry and child psychiatry by the American Board of Psychiatry and Neurology. He is also board certified by the National Board of Medical Examiners and the American Board of Medical Management. He is retired from the United States Army as a Brigadier General. His assignments while on active duty include Commander, Blanchfield Army Community Hospital and Commanding General, Southeast Regional Medical Command and Dwight David Eisenhower Army Medical Center. He is currently in private practice.

3. Expert consultant's address and telephone number:

[redacted]

4. Complete statement of reasons why the expert consultant is necessary:

a. Why the expert consultant is needed:

i. The defense must fully understand Mr. Khadr's current physical and cognitive status to ensure his full participation in his defense. He was 15 years old at the time of the battle in which he was captured. Since that time has been held in continual confinement, often solitary confinement, and without any accommodation for his age. The effect that has had on his physical and cognitive development and consequently his ability to assist his attorneys in his defense is uncertain. Additionally, he was repeatedly interrogated and questioned, and often subject to harsh or

DEPARTMENT OF DEFENSE
OFFICE OF THE CHIEF DEFENSE COUNSEL
OFFICE OF MILITARY COMMISSIONS

2 May 2008

MEMORANDUM FOR THE CONVENING AUTHORITY

Subj: *UNITED STATES V. KHADR* - REQUEST FOR APPOINTMENT OF EXPERT CONSULTANT [redacted] TO THE DEFENSE TEAM

Encl: (1) Curriculum Vitae of Dr. [redacted]
(2) MC Form 13-1

1. The defense in United States v. Omar Khadr requests the Convening Authority approve Dr. Katherine Porterfield as an expert consultant in the field of Clinical Psychology.

2. Qualifications: Dr. [redacted] is a New York State Licensed Clinical Psychologist specialized in evaluating and treating victims of trauma, particularly juveniles. For the past five years she has been on the faculty of New York University, School of Medicine. For the past seven years, she has been the co-director of the Bellevue/New York University Program for the Survivors of Torture, where she serves as a child psychologist and counselor to survivors of war trauma. She has excellent academic credentials and has lectured and authored numerous articles on the effects and treatment of war trauma on juveniles.

3. Expert consultant's address and telephone number:

[redacted]

4. Complete statement of reasons why the expert consultant is necessary:

a. Why the expert consultant is needed:

i. The defense must fully understand Mr. Khadr's current mental health status to ensure his full participation in his own defense. He was 15 years old at the time of the battle in which he was captured and has since that time been held in continual confinement with adult detainees. What effect that has had on his development and consequently his ability to assist his attorneys in his defense is uncertain. Additionally, he was repeatedly interrogated and questioned, and often subject to harsh or difficult treatment. This treatment continues to impact his mental health and has proven to be a persistent obstacle in consulting with him and in preparing his defense.

ii. A complete mental health examination must be conducted in order to determine if Mr. Khadr has any mental disorder. It must be determined whether Mr. Khadr has the symptoms of any syndrome, such as Posttraumatic Stress Disorder, usually associated with one or more traumatic events. His treatment by his parents, the events leading up to the battle, the battle itself, his own injuries, his subsequent confinement, his learning of the death of his father and the serious crippling of his younger brother are all examples of traumatic events that may have resulted in a mental disorder, condition or syndrome.

iii. [redacted][1]

iv. This request for the services of [redacted] is being made in conjunction with that for Dr. [redacted], a psychiatrist with a certified specialization in child development. Juvenile mental health and juvenile justice experts informed defense counsel that in murder cases both a clinical psychologist and a psychiatrist are routine and necessary to evaluate the individual's fitness to stand trial. A clinical psychologist, such as [redacted], is qualified to administer and interpret neuropsychological tests, such as intelligence, personality, and neuropsychological function tests as well as projective testing that could reveal any thought disorder. These tests can only be performed by a clinical psychologist and are necessary to the kind of comprehensive psychiatric assessment that is required to rule out brain damage that would be difficult or impossible to detect by counsel or even a trained psychiatrist. The likelihood of brain damage for someone such as Mr. Khadr is considerable given the blunt trauma to the head he suffered and the age at which he suffered it. These unresolved questions go directly to his competence to stand trial, provide evidence, understand the nature and gravity of court proceedings and otherwise cooperate in his defense.

[1] The information in this paragraph is classified and will be provided to the Convening Authority next week.

b. What would expert assistance accomplish for the accused:

i. It must be determined what effects his lengthy confinement and treatment have had on Mr. Khadr's ability to accurately recall the events leading up to his capture. The defense must also assess and explore whether his interrogations, questioning and confinement have had any improper or unduly suggestive influences on any statements he has made since his capture.

ii. The defense must determine what effect Mr. Khadr's childhood environment, education and upbringing has had on his decision making and actions during June and July 2002.

iii. Mr. Khadr's current state of mental health must be assessed in order to properly evaluate his ability to testify on his own behalf.

iv. The defense must independently assess whether Mr. Khadr requires any immediate or future mental health treatment, to include possible trauma counseling so that he may participate in his own defense.

v. It must be determined what, if any, effect his current confinement conditions are having on his mental state and continued ability to participate in his own defense.

vi. Mr. Khadr has made serious allegations regarding his treatment while detained in U.S. custody. These allegations along with behavioral observations made by his counsel suggest that Mr. Khadr may have been subject to cruel, inhuman and degrading treatment, and possibly torture. Dr. [redacted] is an expert in diagnosing and treating victims of abuse and her consultation will be necessary to developing the factual predicates for the exclusion of evidence and in mitigation of any sentence should he be found guilty.

c. Why the defense counsel is unable to gather and present the evidence:

What have you done to educate yourself in the requested area of expertise? What treatises have you examined?

By definition, the advice of independent mental health professionals cannot be obtained through independent study or preparation. No member of the defense team has sufficient academic or practical experience to perform the necessary analysis. The defense team is not versed in the science of psychology or sociology, and cannot hope to perform the required testing or analysis on our own. The materials and treatises required to verse themselves are highly technical and presuppose a breadth of previous scientific education no member of the defense team has.

What experts and government employees having knowledge in this area have you interviewed?

We have consulted directly with Dr. [redacted], a clinical child psychiatrist, and Dr. [redacted], a child developmental psychologist, who recommended the expert analysis of a Clinical Psychologist for the purpose of evaluating Omar's fitness to stand trial and cooperate in mounting his defense. [redacted] of the Juvenile Law Center also recommended the expert consultation of a clinical psychologist with Dr. [redacted] qualifications as the routine and necessary component to the adequate defense of a juvenile defendant, especially when that juvenile is charged with a violent crime.

What do you need to learn that you stil1 do not understand in order to defend the accused in this case?

As stated above, an independent psychological assessment is needed for the defense's own consultations with Mr. Khadr, the evaluation of Mr. Khadr's capacity to stand trial and to testify on his own behalf, understanding the full scope of the pressures affecting his behavior both on the dates relevant to his indictment as well as during incarceration and to prepare adequately for issues likely to arise in arguments for mitigation of responsibility and the standards applicable for sentencing.

Are there experts other than the one you requested who would meet your needs? Have you talked to them? Would providing a government employee as an expert consultant meet your needs?

There are other experts who would meet some of the needs we have stated above. The difficulty presented is that most mental health professionals are competent in some but not all of the areas identified above as crucial to an adequate defense. Dr. [redacted] has expertise in the mental health effects of war trauma and prolonged and difficult incarceration. Moreover, she is also a specialist on juvenile mental health issues and the important, and distinct, implications that adolescent development will likely have to the adequate defense of Mr. Khadr. She is therefore uniquely qualified to serve the consultative function proposed and obviates the need to enlist two or more experts to cover her subject matter. Because it is necessary to have an independent assessment and because of Mr. Khadr's skepticism of government agents, a government employee would be inadequate to this function.

What is the nature of any confidential communication you wish to protect? What need, if any, would there be for your client and the expert to talk with each other?

Because of the attorney-client, attorney work-product and doctor-patient privileges, all communications relating to Dr. [redacted] consultations would have to be kept confidential. Due to the nature of the expert advice sought, it would be necessary for Mr. Khadr and Dr. [redacted] to conduct a series of visits during which Dr. [redacted] could develop an adequate doctor-patient rapport as

well as conduct a thorough investigation. There is an additional possibility that Dr. [redacted] will be called to testify at trial or at sentencing. In such case, her analysis and communications with Mr. Khadr may be disclosed as necessary for the conduct of trial.

5. Estimated Cost:

a. Total hours/days and total cost:

[redacted] fees are $250.00 per hour plus expenses for consultation, analysis and/or review. We request authorization of up to 100 hours of her consultative services, so that she may meet with Mr. Khadr long enough to both develop a rapport and conduct the necessary examinations, may write up her findings for use by the defense team, may consult directly with the defense team as to her findings and may ultimately be called as an expert witness at trial. The Defense therefore requests authorization for up to $25,000 in fees to Dr. [redacted]

b. Total days TDY at the per diem rate (such as travel days and casual status), if any:

To conduct a standard consultation, Dr. [redacted] would require 4 to 5 days with Mr. Khadr with two travel days for travel to and from GTMO. Equally, if Dr. [redacted] were called upon to testify, further days TDY would be required to receive his testimony.

c. Travel costs, if any:

Dr. [redacted] would, at a minimum, require travel and lodging at Guantanamo Bay, Cuba for a duration long enough to meet with and evaluate Mr. Khadr.

d. Rate for professional services and hours/days (when travel is not involved):

Dr. [redacted] typically charges $250.00 per hour for consultative services.

e. Inconvenience fee, in any:

None requested.

6. On 2 May 2008, I notified the opposing party of this request.

7. In the event this request is denied, the Defense requests a written response articulating the reasons for the denial. Should you have any questions or require further information, please contact me at [redacted]

WILLIAM KUEBLER
LCDR, JAGC, USN
Detailed Defense Counsel

CC: Chief Defense Counsel
Major Grohairing, Lead Prosecutor

Attachment A

[redacted]

Figure 13.1 Sample Memorandum of Agreement for Use with Civilian Expert Witness (MC Form 13-1)

SAMPLE MEMORANDUM OF AGREEMENT FOR USE OF CIVILIAN EXPERT (CONSULTANT) ~~(WITNESS)~~

1. (Dr.)~~(Mr.)(Ms.)~~ [redacted] is hereby retained as an expert witness to provide review, analysis, consultation (and testimony), as needed, in the military commission of United States v. Omar Khadr, on behalf of the ~~(government)~~ (defense).

2. The expert witness agrees to provide the following services:

a. To review all documentation relevant to the area of expertise which pertains to the guilt or innocence of the accused, and which has been provided by the (trial counsel) (defense counsel).

b. To act as an expert technical consultant for the ~~(government)~~ (defense).

c. To assist the ~~(trial counsel)~~ (defense counsel) to prepare for the expert witness' in-court testimony, and to be available for pretrial interview by opposing counsel.

d. To travel to the location of the trial on invitational travel orders and to testify on behalf of the ~~(Government)~~ (defense), and, if requested by the ~~(trial counsel)~~ (defense counsel), to sit in on and evaluate the testimony of any expert witness for the opposing side.

e. To provide a copy of the expert's resume or curriculum vitae to the ~~(trial counsel)~~ (defense counsel).

f. To submit a government travel voucher for payment, following the instructions provided, and accompanied by required documentation of travel, lodging, and other expenses.

g. To certify that the fee charged for expert services is no greater than the expert's normal professional rate.

3. The Government agrees to pay the expert witness, as follows:

a. To reimburse actual travel costs, either coach air travel, or mileage, according to the Joint Travel Regulation.

b. To pay per diem for meals, and the lesser of actual cost of lodging or the government local lodging rate, including payment for all travel days, according to the Joint Travel Regulation.

c. To pay a fee of $ N/A per day for in-court testimony.

Attachment A

DEPARTMENT OF DEFENSE
OFFICE OF THE CHIEF DEFENSE COUNSEL
OFFICE OF MILITARY COMMISSIONS

2 May 2008

MEMORANDUM FOR THE CONVENING AUTHORITY

Subj: *UNITED STATES V. KHADR* - REQUEST FOR APPOINTMENT OF EXPERT CONSULTANT BRIGADIER GENERAL [redacted], M.D. (RET'D), TO THE DEFENSE TEAM

Encl: (1) Curriculum Vitae of Dr. [redacted]
(2) MC Form 13-1

1. The defense in United States v. Omar Khadr requests the Convening Authority approve BG [redacted], M.D. (Ret'd), as an expert consultant in the field of Developmental Psychiatry.

2. Qualifications: Dr. [redacted] is a clinical psychiatrist and an expert in the area of child and adolescent psychiatry. He is board certified in general psychiatry and child psychiatry by the American Board of Psychiatry and Neurology. He is also board certified by the National Board of Medical Examiners and the American Board of Medical Management. He is retired from the United States Army as a Brigadier General. His assignments while on active duty include Commander, Blanchfield Army Community Hospital and Commanding General, Southeast Regional Medical Command and Dwight David Eisenhower Army Medical Center. He is currently in private practice.

3. Expert consultant's address and telephone number:

[redacted]

4. Complete statement of reasons why the expert consultant is necessary:

a. Why the expert consultant is needed:

i. The defense must fully understand Mr. Khadr's current physical and cognitive status to ensure his full participation in his defense. He was 15 years old at the time of the battle in which he was captured. Since that time has been held in continual confinement, often solitary confinement, and without any accommodation for his age. The effect that has had on his physical and cognitive development and consequently his ability to assist his attorneys in his defense is uncertain. Additionally, he was repeatedly interrogated and questioned, and often subject to harsh or

difficult treatment. This treatment continues to impact his mental health and has proven to be a persistent obstacle in consulting with him and in preparing his defense.

ii. A complete physical and mental health examination must be conducted in order to determine if Mr. Khadr has any physical or cognitive disorder that could impair his mental capacities, especially as they relate to his memory and understanding of the events around him. Mr. Khadr was seriously wounded in July 2002, shrapnel remains in his head, he has lost the vision of his left eye, has poor vision in his right eye and endures a variety of other physical ailments that could greatly contribute to cognitive impairment.

iii. It is also necessary for a psychiatrist with expertise in adolescent development to assess what Mr. Khadr's level of cognitive development, awareness of his circumstances and capacity for independent thought and action would have been at the age when he was wounded, captured and alleged to have freely engaged in criminal conduct.

iv. [redacted][1]

v. This request for the services of [redacted] is being made in conjunction with that for [redacted], a clinical psychologist specialized in juvenile development and war trauma. Juvenile mental health and juvenile justice experts informed defense counsel that in murder cases both a clinical psychologist and a psychiatrist are routine and necessary to evaluate the individual's fitness to stand trial. A developmental psychiatrist, such as [redacted] must integrate the neuropsychological findings provided by Dr. [redacted] with Mr. Khadr's family, medical and mental health history. Dr. [redacted] is uniquely qualified as a psychiatrist to incorporate his evaluation of Mr. Khadr's physical and mental health, including a mental status examination, into a complete diagnosis that must serve to rule out any potential brain damage or neurological disorder. The

[1] The information in this paragraph is classified and will be provided to the Convening Authority next week.

likelihood of brain damage for someone such as Mr. Khadr is considerable given the blunt trauma to the head he suffered and the age at which he suffered it. These unresolved questions go directly to his competence to stand trial, provide evidence, understand the nature and gravity of court proceedings and otherwise cooperate in his defense.

b. What would expert assistance accomplish for the accused:

i. It must be determined what effects Mr. Khadr's lengthy confinement, physical health and treatment have had on his ability to accurately recall the events leading up to his capture. The defense must also assess and explore whether his interrogations, questioning and confinement have had any improper or unduly suggestive influences on any statements he has made since his capture. Furthermore, observations of counsel indicate potential symptoms of disorders in cognitive development that could be impairing his ability to assist in his defense.

ii. His current phase of cognitive development and physical health must also be independently assessed in order to evaluate his ability to testify on his own behalf.

iii. The defense must independently assess whether Mr. Khadr requires any immediate or future medical or mental health treatment, to include possible psychiatric treatment or treatment for the extensive physical trauma he suffered to his body, eyes and head. Additionally, it must be determined what, if any, effect his current confinement conditions are having in arresting his development in ways that could affect his capacity to participate in his own defense.

c. Why the defense counsel is unable to gather and present the evidence:

What have you done to educate yourself in the requested area of expertise? What treatises have you examined?

By definition, the advice of independent medical professionals cannot be obtained through independent study or preparation of Mr. Khadr's counsel. No member of the defense team has sufficient academic or practical experience to perform medical evaluations. No member of the defense team is a qualified physician and performing the necessary evaluation without such qualifications or licensing would likely be unlawful. *See, e.g.*, D.C. Code §§ 3-1210.01, 3-1210.07.

What experts and government employees having knowledge in this area have you interviewed?

We have consulted directly with Dr. [redacted], a clinical child psychiatrist, who identified the need to have a psychiatric medical evaluation of the kind described above and directed the defense team to Dr. [redacted] with the strongest

possible recommendation. [redacted] of the Juvenile Law Center also recommended that Mr. Khadr be evaluated by an independent psychiatrist with [redacted]' qualifications and indicated that this was a routine and necessary component to the adequate defense of a juvenile defendant, especially when that juvenile is charged with a violent crime.

What do you need to learn that you stil1 do not understand in order to defend the accused in this case?

As stated above, an independent medical and psychiatric assessment is needed for the defense's own consultations with Mr. Khadr, his capacity to stand trial and to testify on his own behalf, to know what cognitive impairments may jeopardize his defense, to understand how his physical condition may have affected his behavior on the dates relevant to his indictment and during his incarceration and to prepare adequately for issues likely to arise in arguments for mitigation of responsibility and the standards applicable for sentencing.

Are there experts other than the one you requested who would meet your needs? Have you talked to them? Would providing a government employee as an expert consultant meet your needs?

There are other experts who would meet some of the needs we have stated above. The difficulty presented is that most psychiatrists are competent in some but not all of the areas identified above as crucial to an adequate defense. Dr. [redacted] is a certified specialist in child psychiatry. Moreover, Dr. [redacted] is a former Brigadier General in the United States Army with extensive experience in the cognitive effects of war trauma and exposure to combat. He is therefore uniquely qualified to serve the consultative function proposed and obviates the need to enlist two or more experts to cover his subject matter. Because it is necessary to have an independent assessment and because of Mr. Khadr's skepticism of government agents, it would be ineffective for a government employee to serve this function.

What is the nature of any confidential communication you wish to protect? What need, if any, would there be for your client and the expert to talk with each other?

Because of the attorney-client, attorney work-product and doctor-patient privileges, all communications relating to Dr. [redacted]' consultations would have to be kept confidential. Due to the nature of the expert advice sought, it would be necessary for Mr. Khadr and Dr. [redacted] to conduct a series of visits during which Dr. [redacted] could develop an adequate doctor-patient rapport as well as conduct a thorough medical evaluation, including electroencephalographic testing to evaluate the neurological effect of the head trauma Mr. Khadr endured as well as how Mr. Khadr's cognitive development compares to other individuals his age. There is an additional possibility that Dr. [redacted] will be called to testify at trial or at sentencing. In such case, his findings and communications with Mr. Khadr may be disclosed as necessary for the conduct of trial.

5. Estimated Cost:

a. Total hours/days and total cost:

Dr. [redacted] typically charges $350.00 per hour plus expenses for consultation, diagnosis and/or review as well as $695.00 per hour for electroencephalography testing. We request authorization of up to 100 hours of his services, so that he may meet with Mr. Khadr long enough to develop a sufficient rapport and to conduct the necessary physical examination, may write up his diagnosis for use by the defense team, may consult directly with the defense team as to his findings and may ultimately be called as an expert witness at trial. The Defense therefore requests authorization for up to $35,000 in fees t[redacted].

b. Total days TDY at the per diem rate (such as travel days and casual status), if any:

To conduct a standard consultation and to conduct the necessary diagnostic testing, Dr. [redacted] would require 4 to 5 days with Mr. Khadr with two travel days for travel to and from GTMO. Equally, if Dr. [redacted] were called upon to testify, further days TDY would be required to receive his testimony.

c. Travel costs, if any:

[redacted] would, at a minimum, require travel and lodging at Guantanamo Bay, Cuba for a duration long enough to meet with and evaluate Mr. Khadr.

d. Rate for professional services and hours/days (when travel is not involved):

Dr. [redacted] $350/hr for assessments and $695 for quantitative electroencephalography testing.

e. Inconvenience fee, in any:

None requested.

6. On 2 May 2008, I notified the opposing party of this request.

7. In the event this request is denied, the defense requests a written response articulating the reasons for the denial. Should you have any questions or require further information, please contact me at [redacted]

WILLIAM KUEBLER
LCDR, JAGC, USN
Detailed Defense Counsel

CC: Chief Defense Counsel
Major Grohairing, Lead Prosecutor

Figure 13.1 Sample Memorandum of Agreement for Use with Civilian Expert Witness (MC Form 13-1)

SAMPLE MEMORANDUM OF AGREEMENT FOR USE OF CIVILIAN EXPERT (CONSULTANT) (WITNESS)

1. ~~(Dr.)(Mr.)(Ms.)~~ [redacted] hereby retained as an expert witness to provide review, analysis, consultation (and testimony), as needed, in the military commission of United States v. Omar Khadr, on behalf of the (government) (defense).

2. The expert witness agrees to provide the following services:

a. To review all documentation relevant to the area of expertise which pertains to the guilt or innocence of the accused, and which has been provided by the (trial counsel) (defense counsel).

b. To act as an expert technical consultant for the (government) (defense).

c. To assist the (trial counsel) (defense counsel) to prepare for the expert witness' in-court testimony, and to be available for pretrial interview by opposing counsel.

d. To travel to the location of the trial on invitational travel orders and to testify on behalf of the (Government) (defense), and, if requested by the (trial counsel) (defense counsel), to sit in on and evaluate the testimony of any expert witness for the opposing side.

e. To provide a copy of the expert's resume or curriculum vitae to the (trial counsel) (defense counsel).

f. To submit a government travel voucher for payment, following the instructions provided, and accompanied by required documentation of travel, lodging, and other expenses.

g. To certify that the fee charged for expert services is no greater than the expert's normal professional rate.

3. The Government agrees to pay the expert witness, as follows:

a. To reimburse actual travel costs, either coach air travel, or mileage, according to the Joint Travel Regulation.

b. To pay per diem for meals, and the lesser of actual cost of lodging or the government local lodging rate, including payment for all travel days, according to the Joint Travel Regulation.

c. To pay a fee of $ N/A per day for in-court testimony.

d. To pay a fee of $$350.^{00}$ per hour for consultation, diagnosis or review and $650.00 per hour for electroencephalogra testing. when professional advice and services are rendered, but no travel or in-court testimony is involved.

e. To pay an inconvenience fee of up to $ N/A if the travel and testimony of the expert witness is canceled or rescheduled within 5 days prior to the expert's scheduled travel day. The witness is expected to reasonably mitigate any financial loss caused by cancellation. This fee is to be reduced to the extent other gainful activities may be undertaken.

4. Payment under this agreement has been approved by the Office of Military Commissions. Payment will be made up to a maximum of $35,000.00 The balance has been approved and will be paid by the military commission convening authority in this case.

Convening Authority/ Date

Expert Witness/ Date

[redacted]

OFFICE OF THE SECRETARY OF DEFENSE
OFFICE OF MILITARY COMMISSIONS
1600 DEFENSE PENTAGON
WASHINGTON, DC 20301-1600

CONVENING AUTHORITY

20 May 2008

MEMORANDUM FOR LCDR William Kuebler, Office of Defense Counsel

SUBJECT: *U.S. v. Khadr*: Response to Request for Expert Consultants [redacted])

I have reviewed your requests for employment of Dr. [redacted] developmental psychiatrist) and Dr. [redacted] (clinical psychologist). As explained below, the requests lack sufficient justification as required by R.M.C. 703(d).

The request for Dr. [redacted] states that "[a] complete physical and mental health examination must be conducted to determine if Mr. Khadr has any physical or cognitive disorder that could impair mental capacities...." The request also states that it is necessary to "assess what Mr. Khadr's level of cognitive development, awareness of his circumstances and capacity for independent thought and action would have been" in July 2002. The request cites "observations of counsel" as evidence to support that Mr. Khadr suffers from a condition that impairs his ability to assist in his defense.

The request for Dr. [redacted] states that "[a] complete physical and mental health examination must be conducted to determine if Mr. Khadr has any mental disorder" and "[i]t must be determined whether Mr. Khadr has the symptoms of any syndrome, such as Posttraumatic Stress Disorder, usually associated with one or more traumatic events." The request lists "treatment by his parents, the events leading up to the battle, the battle itself, his own injuries, his subsequent confinement, his learning of the death of his father and the serious crippling of his younger brother" as examples of such traumatic events. The request also refers to "serious allegations regarding his treatment while detained" and "behavioral observations made by his counsel."

R.M.C. 703(d) states that a request for an expert consultant "shall include a complete statement of reasons why the expert is necessary." In construing R.M.C. 703(d), I apply the following test set forth in *United States v. Bresnahan*, 62 M.J. 137, 143 (C.A.A.F. 2005) (quoting *United States v. Gunkle*, 55 M.J. 26, 31 (C.A.A.F. 2001) and *United States v. Robinson*, 39 M.J. 88, 89 (C.A.A.F. 1994)):

> An accused is entitled to an expert's assistance before trial to aid in the preparation of his defense upon a demonstration of necessity. But necessity requires more than the "mere possibility of assistance from the requested expert" . . . The accused must show that a reasonable probability exists "both that an expert would be of assistance to the defense and that denial of an expert would result in a fundamentally unfair trial."

[redacted]

Attachment C

[redacted]

> We apply a three-part test to determine whether expert assistance is necessary. The defense must show: (1) why the expert assistance is needed; (2) what the expert assistance would accomplish for the accused; and (3) why the defense counsel were unable to gather and present the evidence that the expert assistance would be able to develop. A military judge's ruling on a request for expert assistance will not be overturned absent an abuse of discretion.

Additionally, on 18 April 2008, I disseminated a form for counsel to use that lays out the requirements of R.M.C. 703(d) and provides instructions.

The request for Dr [redacted] does not satisfy R.M.C. 703(d) or *Bresnahan*. The request suggests the mere possibility that Mr. Khadr suffers from a physical or cognitive disorder based on counsel's observations of his behavior. However, the request does not state those behaviors or how those observations led to counsel's conclusion that Mr. Khadr suffers from a physical or cognitive disorder. Furthermore, the request did not include any records that suggest Mr. Khadr suffers from such a disorder. [redacted]

The request for Dr. [redacted] similarly suggests that Mr. Khadr has a mental disorder, but does not explain the underlying facts. The request does not inform me how Mr. Khadr's parents treated him or what events led to the 27 July 2002 firefight, nor does it explain these events' relevance to Mr. Khadr's mental health. Nor does it explain Mr. Khadr's allegations of mistreatment or counsel's behavioral observations that suggest cruel, inhumane or degrading treatment or possible torture. Furthermore, the request does not include any records which suggest Mr. Khadr has a mental disorder.

Your requests only speculate that Mr. Khadr may suffer from a mental disease or defect that may render him unable to understand the nature of the proceedings against him or to conduct or cooperate intelligently in his defense. Such speculation of possible assistance is insufficient under R.M.C. 703(d).

I encourage you to continue to pursue your requests and follow up with any concerns.

Susan J. Crawford
Convening Authority
for Military Commissions

[redacted]

Attachment C

[redacted]

AFFIDAVIT OF OMAR AHMED KHADR

I, OMAR AHMED KHADR, make oath and say as follows.

1. I am the Applicant in these proceedings and as such have personal knowledge of the matters hereinafter deposed to save and except where stated to be based upon information and belief.

2. I am a Canadian citizen. My date of birth is September 19, 1986.

3. I am a prisoner in Guantanamo Bay, Cuba. I was first taken prisoner by U.S. forces on July 27, 2002, when I was 15 years old. I was severely wounded in the battle where I was captured. I was shot at least twice in the back, at least once through my left shoulder exiting through my left breast, and once under my right shoulder, exiting out of my upper right side. I was also struck with shrapnel in my left eye, and was wounded in my left thigh, knee, ankle and foot.

4. I believe I remained conscious after being wounded and captured. I remember being carried by my arms and legs to an area in the open where someone put some bandages on me. The soldiers were asking me questions about my identity. They then placed me on a wooden board and carried me into a helicopter. I lost consciousness during the trip in the helicopter.

5. I was unconscious for about one week after being captured. When I began to regain consciousness I asked what the date was and knew that I had been unconscious for a week since being captured. I was awake, but I was not right and was out of my wits for about three days. I was in extreme pain and my pain was all I could focus on. I was in a tent hospital on a stretcher. There were two other detainees there with me, one had lost both his legs and often screamed for pain medication. The other detainee was an older man.

6. While at the tent hospital I was guarded day and night by pairs of soldiers. During the day, I was guarded by a young blond soldier who was about 25, and a Mexican or Puerto Rican soldier.

7. During the first three days I was conscious in the tent hospital, the first soldier would come and sit next to my stretcher and ask me questions. He had paper and took notes. During the first three days, they would shackle my feet and hands out to my sides with handcuffs when they did not like the answers I was giving to the questions. Due to my injuries, this caused me great pain. At least two of the interrogations during these first three days occurred when I was shackled by my hands and feet and in pain. I was unable to even stand at this time, so I was not a

threat, and I could tell that this treatment was for punishment and to make me answer questions and give them the answers they wanted.

8. The Hispanic MP acted like he hated me, and would often shackle me and cause me pain. He would tell the nurses not to speak nicely or softly to me since he said that I had killed an American soldier. He would also insult me quite often.

9. There were no doctors or nurses present when I was interrogated. During the interrogations, the pain was taking my thoughts away. After I regained consciousness after being unconscious for a week, the first soldier told me that I had killed an American with a hand grenade. They would only give me pain medication at nighttime but the interrogations occurred during the daytime.

10. After about 2 weeks in the hospital I was immediately taken to an interrogation room at a military camp in Bagram. I was left in the room for about 1 hour by myself. Then someone came in and started interrogating me. This interrogation lasted for about 3 hours. It was a skinny white interrogator with glasses who seemed to be about 25 years old. He had a small tattoo on the top of his forearm. He wore desert camouflage pants but a different kind of shirt. They asked me all kinds of questions about everything and I don't remember all the questions today.

11. During this first interrogation, the young blonde man would often scream at me if I did not give him the answers he wanted. Several times, he forced me to sit up on my stretcher, which caused me great pain due to my injuries. He did this several times to get me to answer his questions and give him the answers he wanted. It was clear that he was making me sit up because he knew that it hurt and he wanted me to answer questions. I cried several times during the interrogation as a result of this treatment and pain.

12. During this interrogation, the more I answered the questions and the more I gave him the answers he wanted, the less pain was inflicted on me. I figured out right away that I would simply tell them whatever I thought they wanted to hear in order to keep them from causing me such pain.

[redacted]

14. The soldiers at Bagram treated me roughly. I was interrogated many, many times by interrogators. For about the first two weeks to a month that I was there I could not get out of the stretcher and would be brought into the interrogation room on a stretcher.

15. During this time, my pain depended upon what I was doing. If I was just relaxing on the stretcher, the pain would be about a 4 or 5 on a scale of 1 to 10. If I was sitting up it was more severe. If I was treated roughly or if my wounds were touched, the pain would be a 10.

16. Everyday when I was at Bagram, five people in civilian clothes would come and change my bandages. They treated me very roughly and videotaped me while they did it.

17. On one occasion, interrogators grabbed and pulled me off the stretcher, and I fell and cut my left knee.

18. On some occasions, the interrogators brought barking dogs into the interrogation room while my head was covered with a bag. The bag was wrapped tighly around my neck, nearly choking me and making it hard to breathe. This terrified me. On other occasions, interrogators threw cold water on me.

19. Several times, the soldiers tied my hands above my head to the door frame or chained them to the ceiling and made me stand like that for hours at a time. Because of my injuries, particularly the bullet wounds in my chest and shoulders, my hands could not be raised all the way above my head, but they would pull them up as high as they thought they could go, and then tie them there.

20. They often made me sit up in the stretcher in order to create pain from my wounds. They knew it was painful for me because of my physical reaction and because I told them it was painful.

21. While my wounds were still healing, interrogators made me clean the floors on my hands and knees. They woke me up in the middle of the night after midnight and made me clean the floor with a brush and dry it with towels until dawn.

22. They forced me to carry heavy buckets of water, which hurt my left shoulder (where I had been shot). They were 5 gallon buckets. They also made me lift and stack crates of bottled water. This was very painful as my wounds were still healing.

23. On several occasions at Bagram, interrogators threatened to have me raped, or sent to other countries like Egypt, Syria, Jordan or Israel to be raped.

24. When I was able to walk again, interrogators made me pick up trash, then emptied the trash bag and made me pick it up again. Many times, during the interrogations, I was not allowed to use the bathroom, and was forced to urinate on myself. They told me that I deserved it.

25. Sometimes they would shine extremely bright lights right up against my face, and my eyes would tear and tear and tear. These lights caused me great pain, particularly since both my eyes were badly injured and had shrapnel in them.

26. Sometimes when they were questioning me, they would tell me that they would let me go free if I told them something that enabled them to catch someone big.

27. One time, an interrogator gave me a pen and paper and told me to write out my story. While I was writing, the Hispanic MP from the tent hospital came up to me, turned around and farted in my face.

28. I think that I was interrogated 42 times in 90 days. I have a memory of 42 times, but I don't recall where I received that number.

29. In Bagram, I would always hear people screaming, both day and night. Sometimes it would be the interrogators screaming at prisoners to stand up or sit down or not to sleep, and sometimes it was the prisoners screaming from their treatment. I know a lot of other detainees who were tortured by the skinny blonde guy. Most people would not talk about what had been done to them. This made me afraid.

30. An old man who was captured with me was also brought to the Bagram camp. I saw bandages and injuries on his legs from where he had been tortured. Later, one of the interrogators told me that this man had died.

31. One time before I left, I had my hands chained above my head to the ceiling, and the skinny blond interrogator with the tattoo told me that I was lucky that I had been injured, he would know how to "treat me," meaning he would torture me.

32. After about three months, I was taken to Guantanamo. For the two nights and one day before putting us on the plane, we were not given any food so that we would not have to use the bathroom on the plane. They shaved our heads and beards, and put medical-type masks over our mouths and noses, and goggles and earphones on us so that we could not see or hear anything. One time, a soldier kicked me in the leg when I was on the plane and tried to stretch my legs.

33. On the plane, I was shackled to the floor for the whole trip. When I arrived at Guantanamo, I heard a military official say, "Welcome to Israel". They half-dragged half-carried us so quickly along the ground off the plane that everyone had cuts on their ankles from the shackles. They would smack you with a stick if you made any wrong moves.

34. They left me in a waiting area for about one hour waiting for processing. They then took me into a room where I was stripped naked and subjected to a body cavity search.

35. I was feeling a lot of back and chest pain from my injuries, and I was also dizzy from the travel, pain and lack of sleep and food.

36. Two soldiers then took charge of me, one was black and one was white. These two soldiers then pushed me up against a wall. One pushed my back into the wall

with his elbow, and the other pushed my face into the wall. Although the goggles and headphones had been removed, the mask was still over my mouth and nose and it was difficult to breathe. They held me like this, and I could not breathe, and passed out. When they felt me falling they would start to relax, but then when I began to wake up, they would do it again until I passed out and began to fall again. They did this to me about 3 or 4 times. There were other prisoners there who were not being treated like this.

37. During processing, they gave me a 2-minute shower, took blood, fingerprints and photographs, including photos of my wounds.

38. I was taken to the Fleet Hospital, where I stayed for two days. While in the hospital, two interrogators came and interrogated me for six hours each day. One interrogator was in civilian dress clothes and I think he told me he was with the FBI. The other was in military camouflage. They asked me questions about everything. I don't think there was anything new. They had papers with them and they took notes.

39. I did not want to expose myself to any more harm, so I always just told interrogators what I thought they wanted to hear. Having been asked the same questions so many times, I knew what answers made interrogators happy and would always tailor my answers based on what I thought would keep me from being harmed.

40. After those first interrogations, I was put into segregation. These are cells with walls, and only a small window that you can't look out of – the window just lets you know if its day or night. There is no human contact.

41. I would often be moved around depending on whether or not I had been co-operating with the interrogators.

42. I was not provided with any educational opportunities, no psychological or psychiatric attention, and was routinely interrogated.

43. While at Guantanamo, I have been visited on numerous occasions by individuals claiming to be from the Canadian government. These included four visits in the course of four days in a row, starting on March 27, 2003.

44. The first visit was by a group of three people: two men, one in his mid-30s and a second, older man, perhaps in his 70s, and a woman about 40-50 years old. The visitors introduced themselves as Canadians. They stated that they knew my mother and grandmother in Scarborough, Canada. We met in a special conference room, rather than the usual interrogation room, and this room was more comfortable. We met for approximately 2-3 hours. Rather than asking me how I was, the visitors had a lot of questions for me.

45. I was very hopeful that they would help me. I showed them my injuries and told them that what I had told the Americans was not right and not true. I said that I told the Americans whatever they wanted me to say because they would torture me. The Canadians called me a liar and I began to sob. They screamed at me and told me that they could not do anything for me. I tried to cooperate so that they would take me back to Canada. I told them that I was scared and that I had been tortured.

46. They came back three more days but I did not sob because they had no sympathy. They asked me about people, such as my father and Arar. They showed me pictures and asked who people were. I told them what I knew.

47. During this second visit, the visitors showed me approximately 20 pictures of various people, and asked me to identify them. The Canadian visitors never asked me how I was feeling or how I was doing, nor did they ever ask if I wanted to send a message to my family.

48. The next day, the two Canadian men who had visited me returned. I told them that if they were not going to help me then I wanted them to leave me alone.

49. On the third visit by the Canadians, I told the Canadian visitors that I wanted to return to my country, Canada, and that I would speak with them there.

50. After the Canadians left and I told the Americans that my previous statements were untrue, life got much worse for me. They took away all of my things except for a mattress. I had no Koran and no blanket. They would shackle me during interrogations and leave me in harsh and painful positions for hours at a time. One navy interrogator would pull my hair and spit in my face.

51. Approximately one month before Ramadan in 2003, two different men came to visit me. They told me that they were Canadian. One of the men was in his 20s and the other in his 30s. These two men yelled at me and accused me of not telling the truth. One of the Canadian men stated, “The U.S. and Canada are like an elephant and an ant sleeping in the same bed,” and that there was nothing the Canadian government could do against the power of the U.S.

52. One of the men returned alone approximately one month after the Eid al-Adha holiday. The visitor showed me his Canadian passport, the outside of which was red in color. The Canadian visitor stated, “I’m not here to help you. I’m not here to do anything for you. I’m just here to get information.” The man then asked me questions about my brother, Abdullah.

53. Within a day of my last visit from the Canadians, my security level was changed from Level 1 to Level 4 minus, with isolation. Everything was taken away from me, and I spent a month in isolation. The room in which I was confined was kept very cold. It was “like a refrigerator”.

54. Around the time of Ramadan in 2003, an Afghan man, claiming to be from the Afghan government, interrogated me at Guantanamo. A military interrogator was in the room at the time. The Afghan man said his name was "Izmarai" (Lion), and that he was from Wardeq. He spoke mostly in Farsi, and a little in Pashto and English. He had an American flag on his trousers. The Afghan man appeared displeased with the answers that I was giving him, and after some time both the Afghan and the military interrogator left the room. A military official then removed my chair and short-shackled me by my hands and feet to a bolt in the floor. Military officials then moved my hands behind my knees. They left me in the room in this condition for approximately five to six hours, causing me extreme pain. Occasionally, a military officer and the interrogators would come in and laugh at me.

55. During the course of his interrogation of me, the Afghan man told me that a new detention center was being built in Afghanistan for non-cooperative detainees at Guantanamo. The Afghan man told me that I would be sent to Afghanistan and raped. The Afghan man also told me that they like small boys in Afghanistan, a comment that I understood as a threat of sexual violence. Before leaving the room, the Afghan man took a piece of paper on which my picture appeared, and wrote on it in the Pashto language, "This detainee must be transferred to Bagram".

56. During one interrogation at Guantanamo in the spring of 2003, an interrogator spit in my face when he didn't like the answers I provided. He pulled my hair, and told me that I would be sent to Israel, Egypt, Jordan, or Syria – comments that I understood to be a threat of torture. The interrogator told me that the Egyptians would send in "Askri raqm tisa" – Soldier Number 9 – which was explained to me was a man who would be sent to rape me.

57. The interrogator told me, "Your life is in my hands". My hands and ankles were shackled, and the interrogator then removed my chair, forcing me to sit on the floor. The interrogator told me to stand up. Because of the way I was shackled, I was not able to use my hands to do so, thus making the act difficult to do. As ordered by the interrogator, I stood up, at which time the interrogator told me to sit down again. When I did so, the interrogator ordered me to stand again. I could not do so, at which point the interrogator called two military police officers into the room, who grabbed me by the neck and arms, lifted me, up, and then dropped me to the floor. The military police officers lifted and dropped me in this manner approximately five times, each time at the instruction of the interrogator. The interrogator told me they would throw my case in a safe and that I would never get out of Guantanamo. This interrogation session lasted for approximately two to three hours.

58. On one occasion at Guantanamo, in the Spring of 2003, I was left alone in an interrogation room for approximately ten hours.

59. Around March of 2003, I was taken out of my cell at Camp Delta at approximately 12:00 – 1:00 a.m., and taken to an interrogation room. An interrogator told me that my brother was not at Guantanamo, and that I should "get ready for a miserable life". I stated that he would answer the interrogator's questions if they brought my brother to see me. The interrogator became extremely angry, then called in military police and told them to cuff me to the floor. First they cuffed me with my arms in front of my legs. After approximately half an hour they cuffed me with my arms behind my legs. After another half hour they forced me onto my knees, and cuffed my hands behind my legs. Later still, they forced me on my stomach, bent my knees, and cuffed my hands and feet together. At some point, I urinated on the floor and on myself. Military police poured pine oil on the floor and on me, and then, with me lying on my stomach and my hands and feet cuffed together behind me, the military police dragged me back and forth through the mixture of urine and pine oil on the floor. Later, I was put back in my cell, without being allowed a shower or change of clothes. I was not given a change of clothes for two days. They did this to me again a few weeks later.

60. When I was moved to Camp 5, I went on a hunger strike. I was very weak and could not stand. Guards would grab me by pressure points behind my ears, under my jaw and on my neck. On a scale of 1 to 10, I would say the pain was an 11. They would often knee me repeatedly in the thighs. Another time, when they took my weight, they pressed on my pressure points. I remember them videotaping me while they did this.

61. I continue to have nightmares. I dream about being shot and captured. I dream about trying to run away and not being able to get away. I dream about all that has happened. About feeling like there is nothing I can do. About feeling disabled. Besides my medical problems, the dreams are the worst right now. I continue to have back pain and pains in my joints.

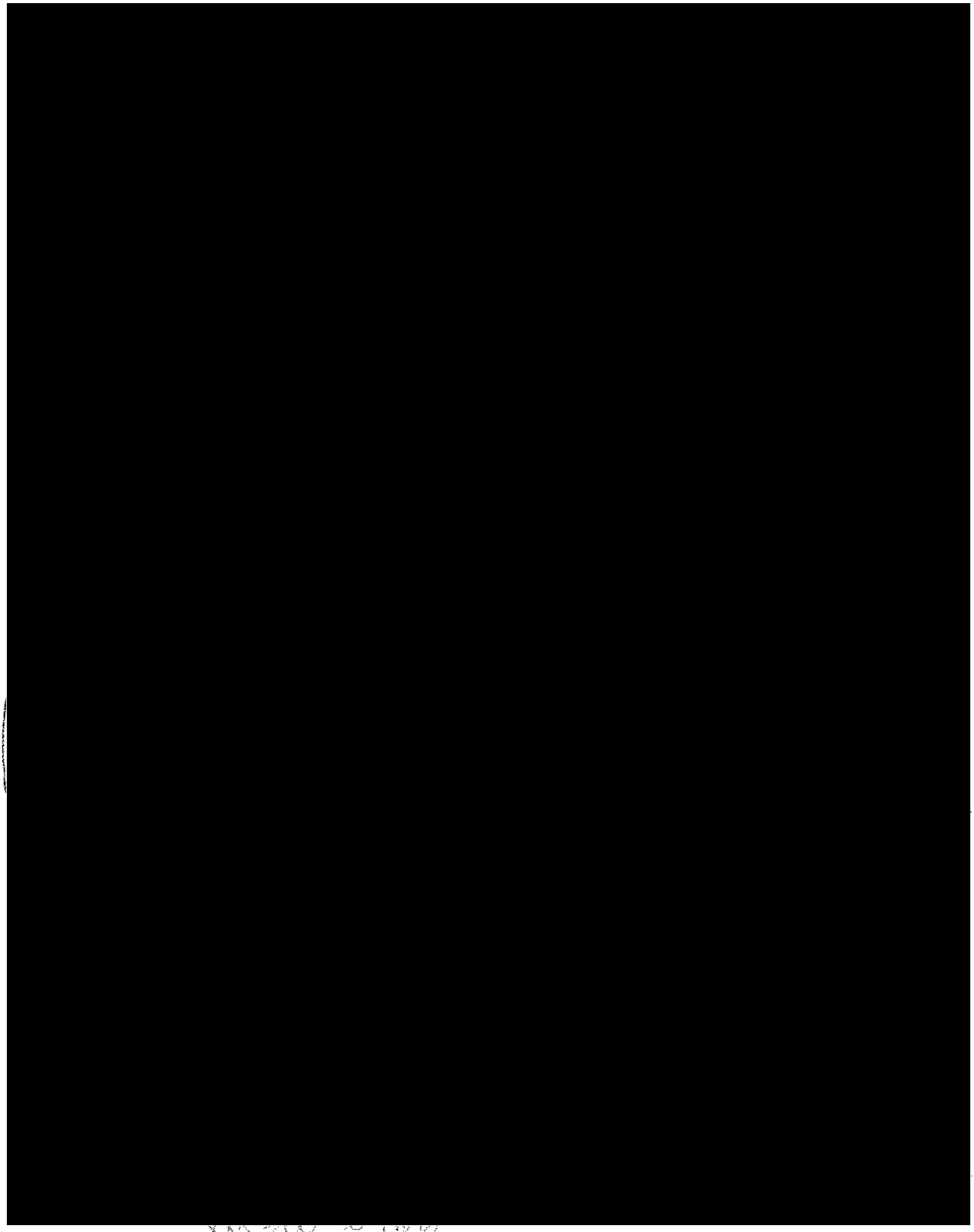
62. I was first visited by lawyers in November of 2004. Before that, I had never been permitted to meet with lawyers.

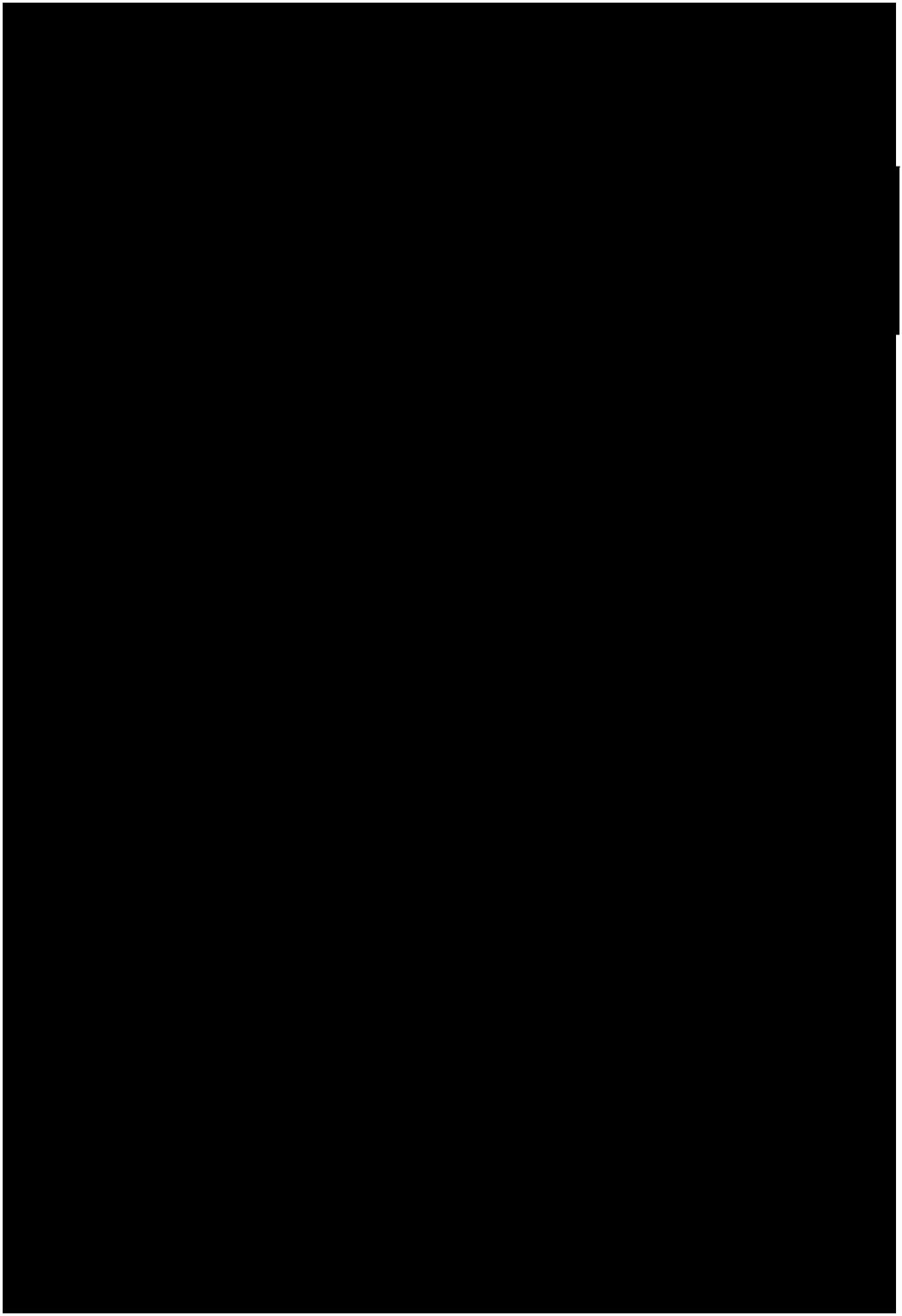
63. In May 2005, they took all of my things including a calendar I had been keeping since sometime in 2004 regarding my treatment, events and other things. They never gave this back.

I solemnly affirm that all of the forgoing statements are true and complete to the best of my knowledge

Omar. A. Khadr

OMAR AHMED KHADR
22 February 2008





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(U) INTERROGATOR NOTES

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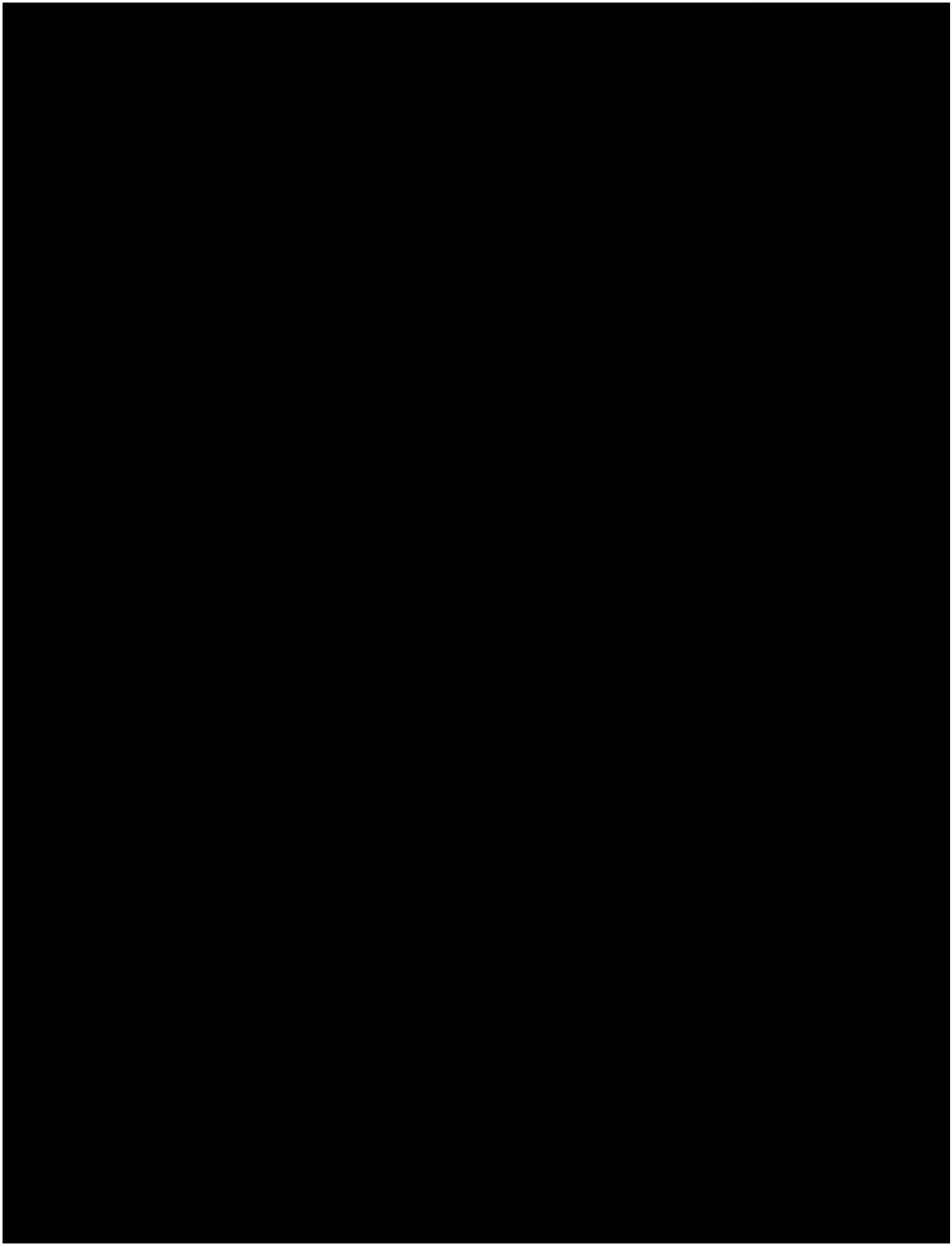

Attachment I

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Attachment L

00766-000144

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[redacted] The guards were advised about the problem and they called medical to come and see KHADR.

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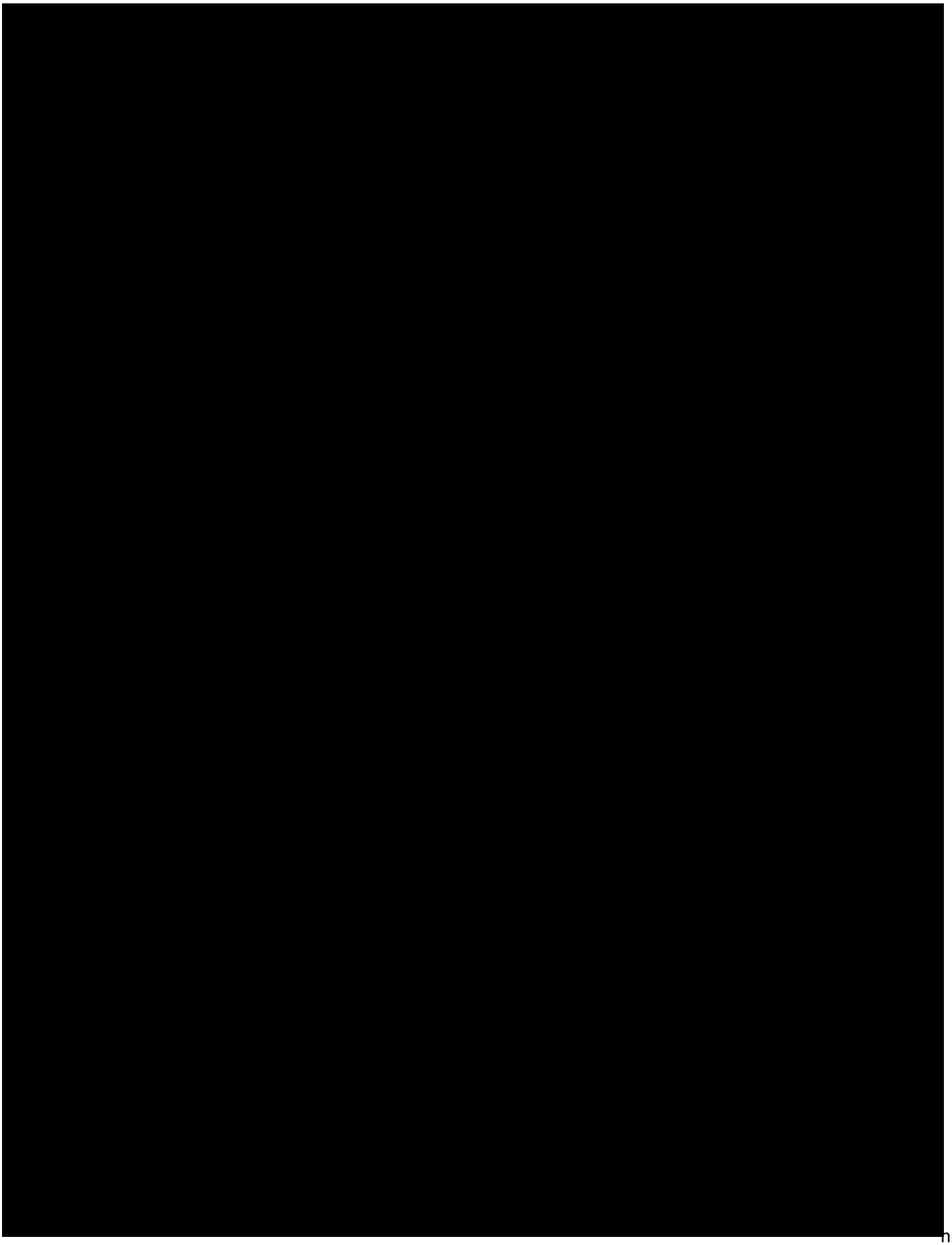
Attachment L

00766-000145



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Attachment N

00766-000150

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Attachment O

00766-000149

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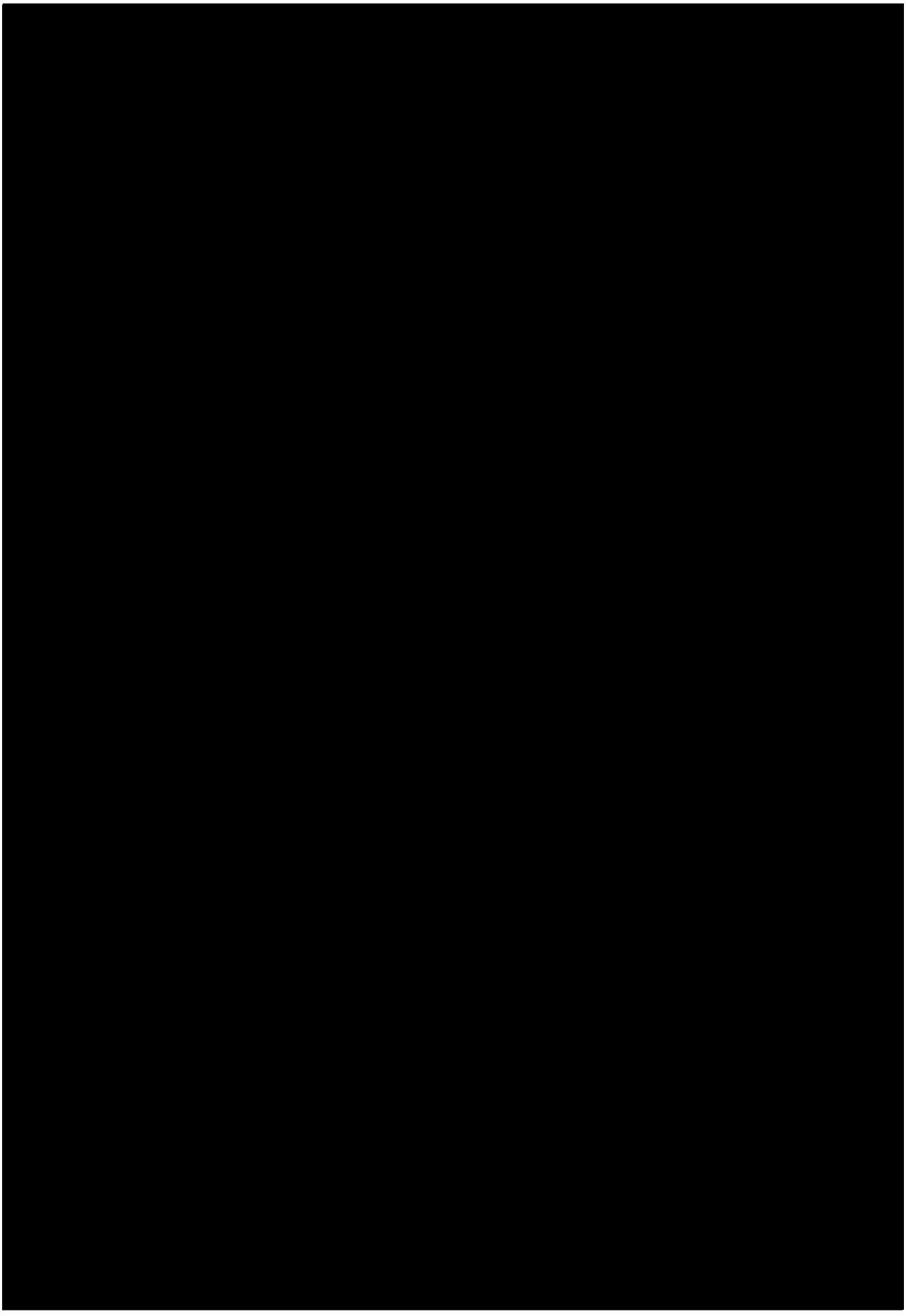

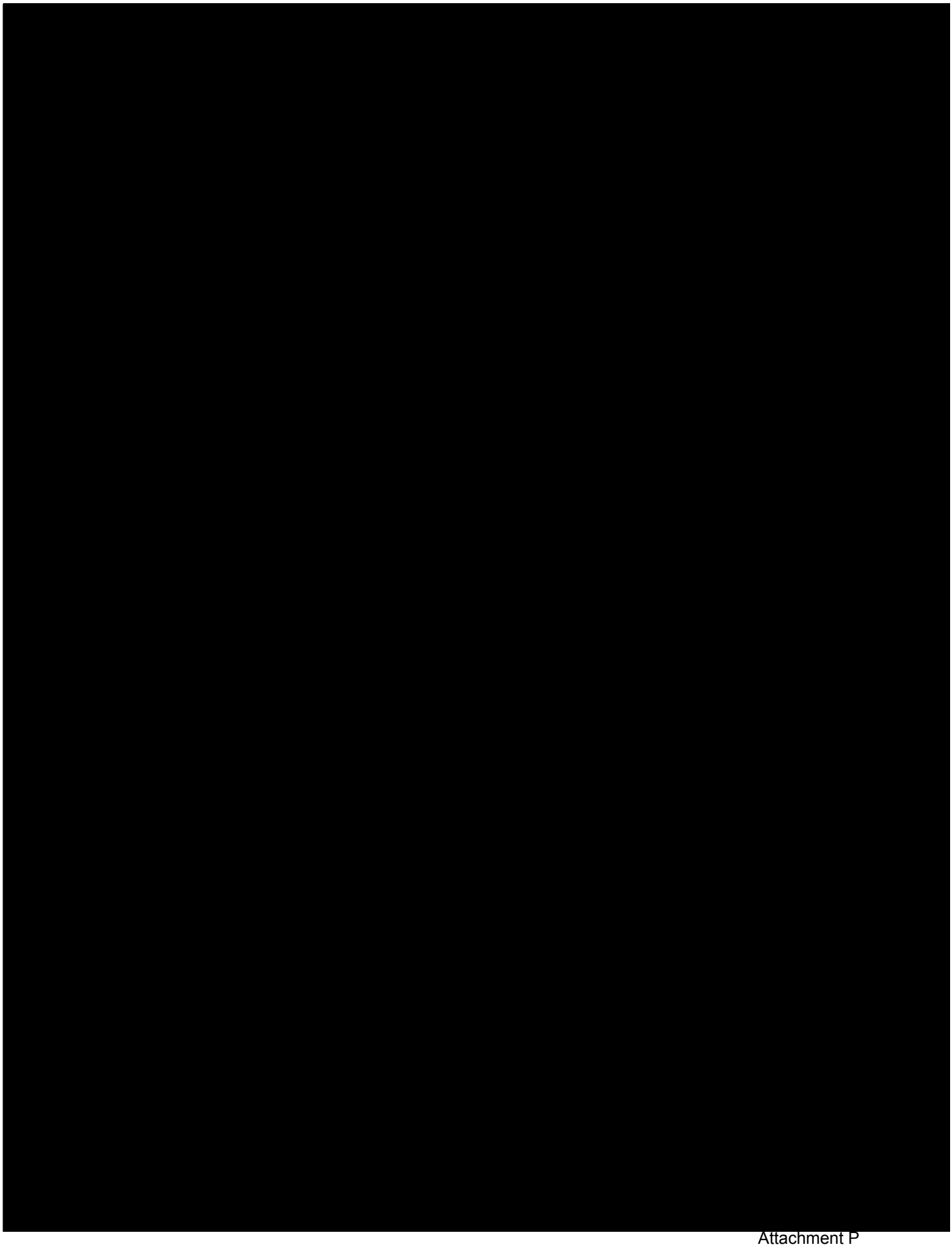

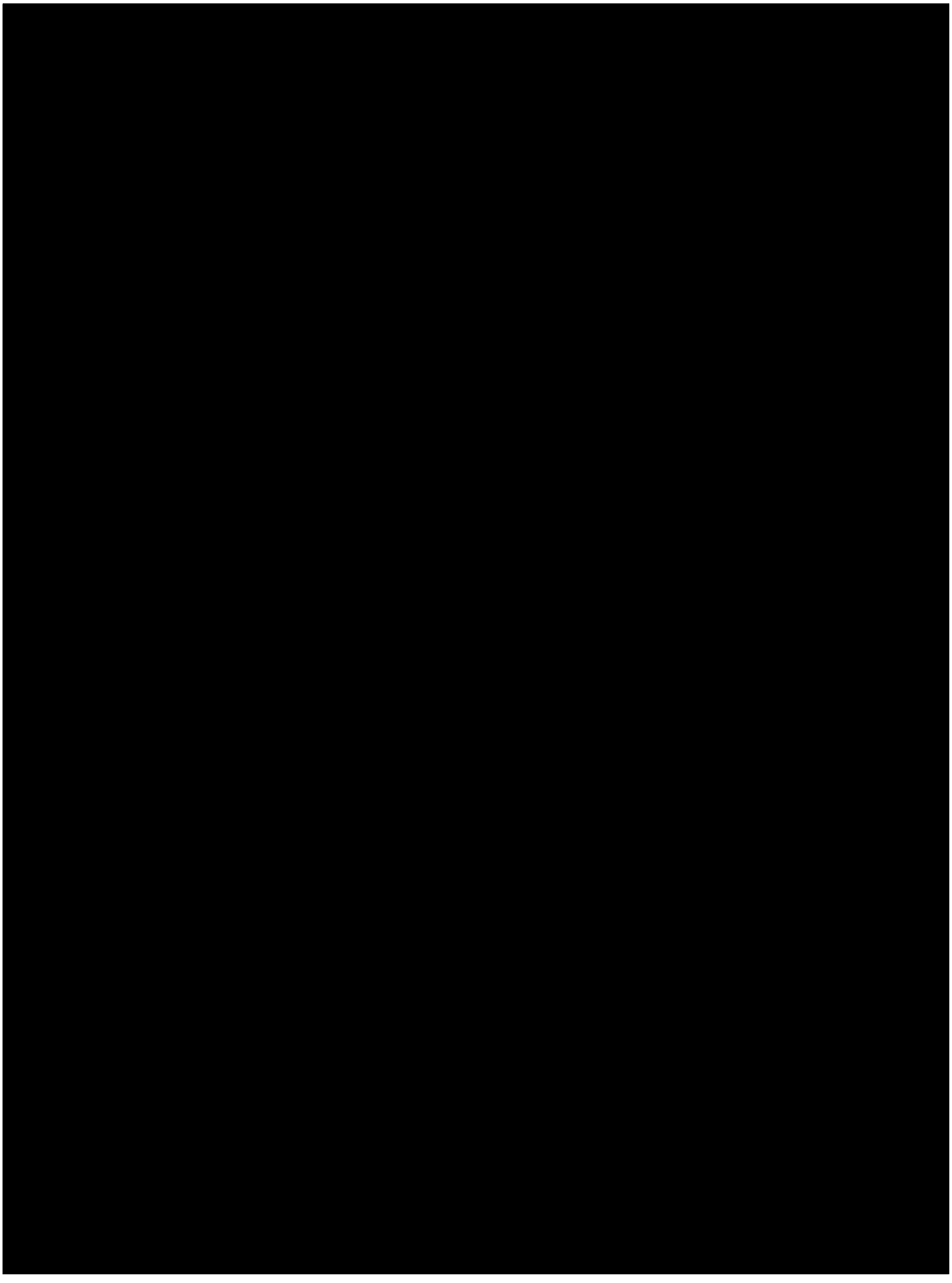

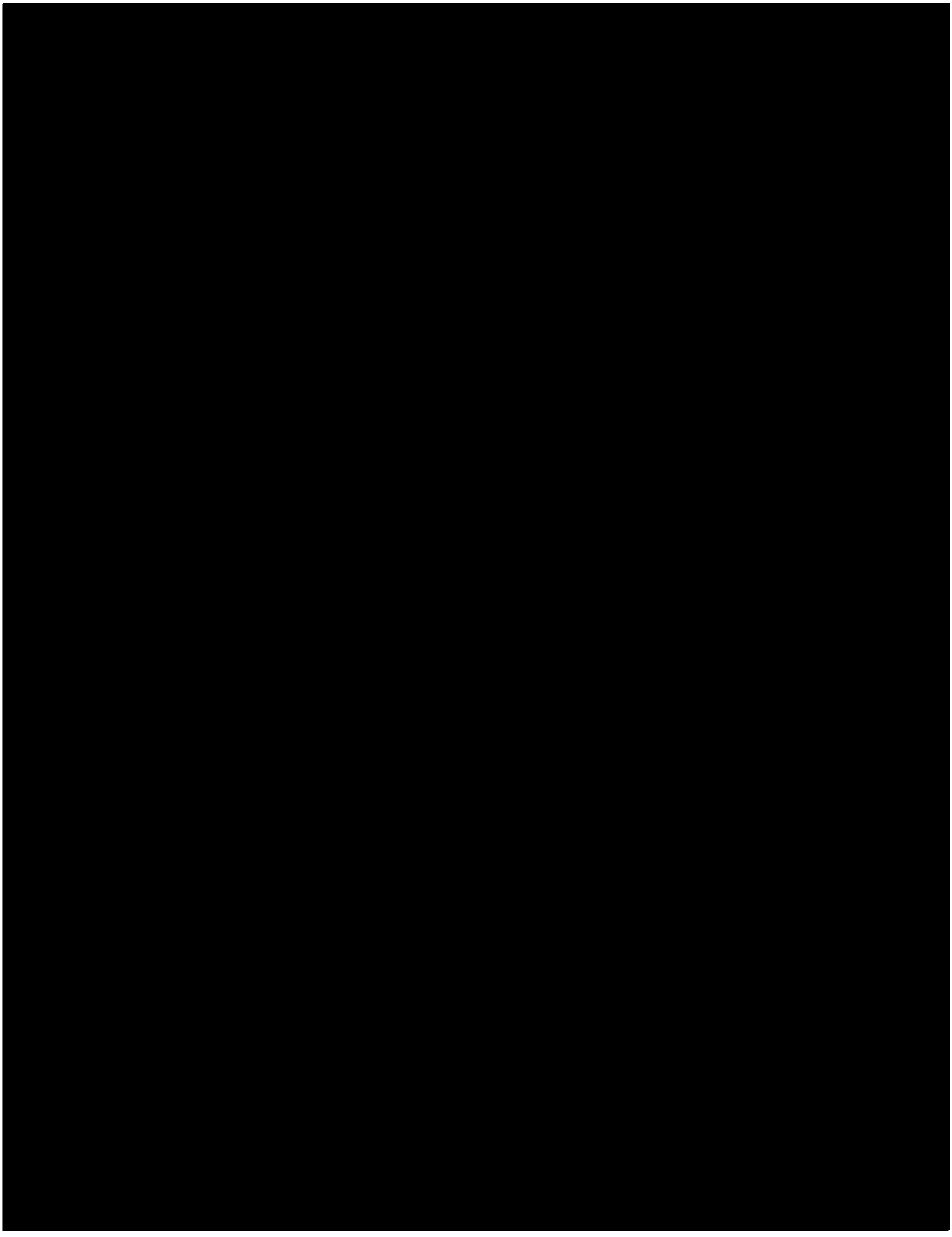

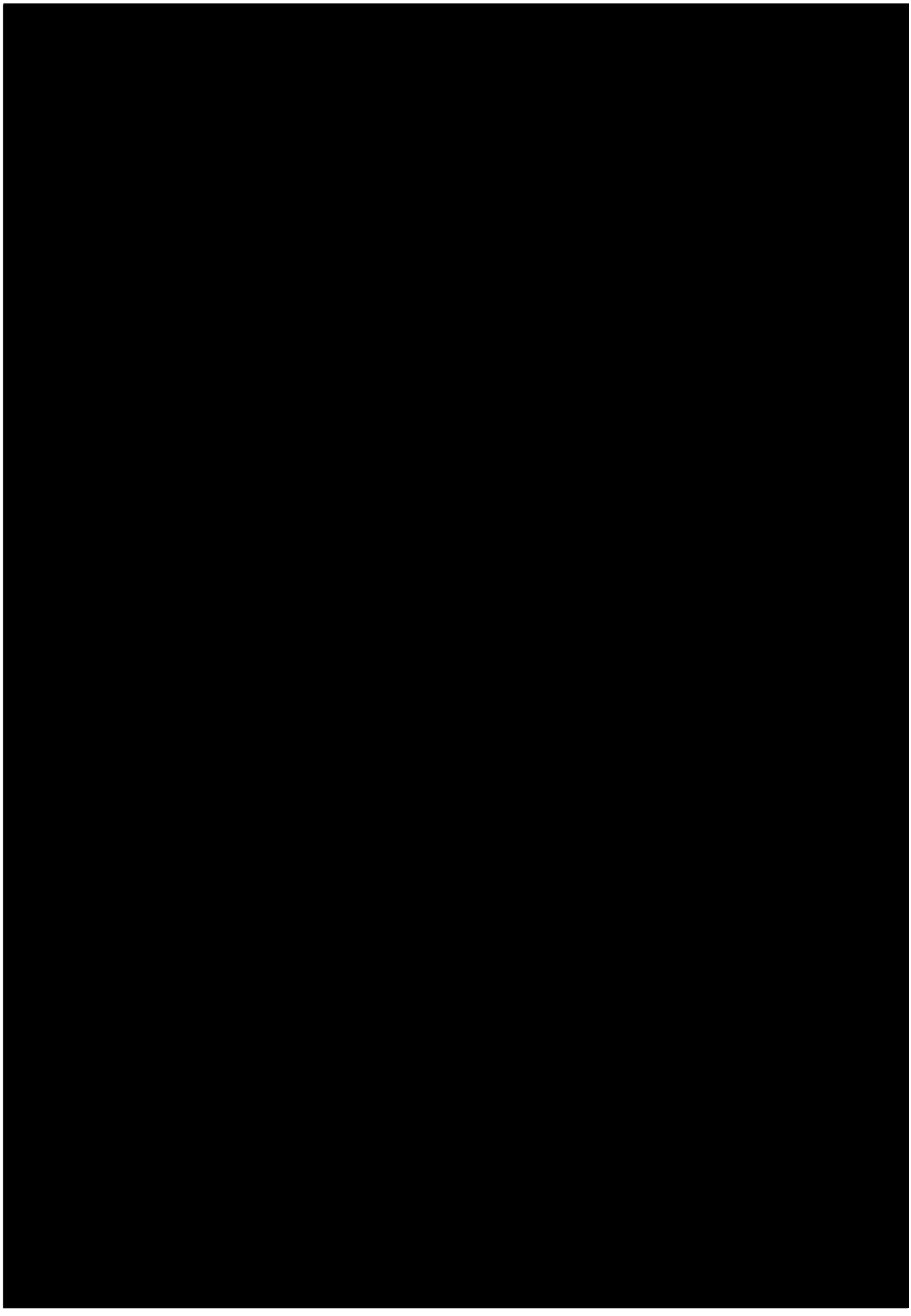

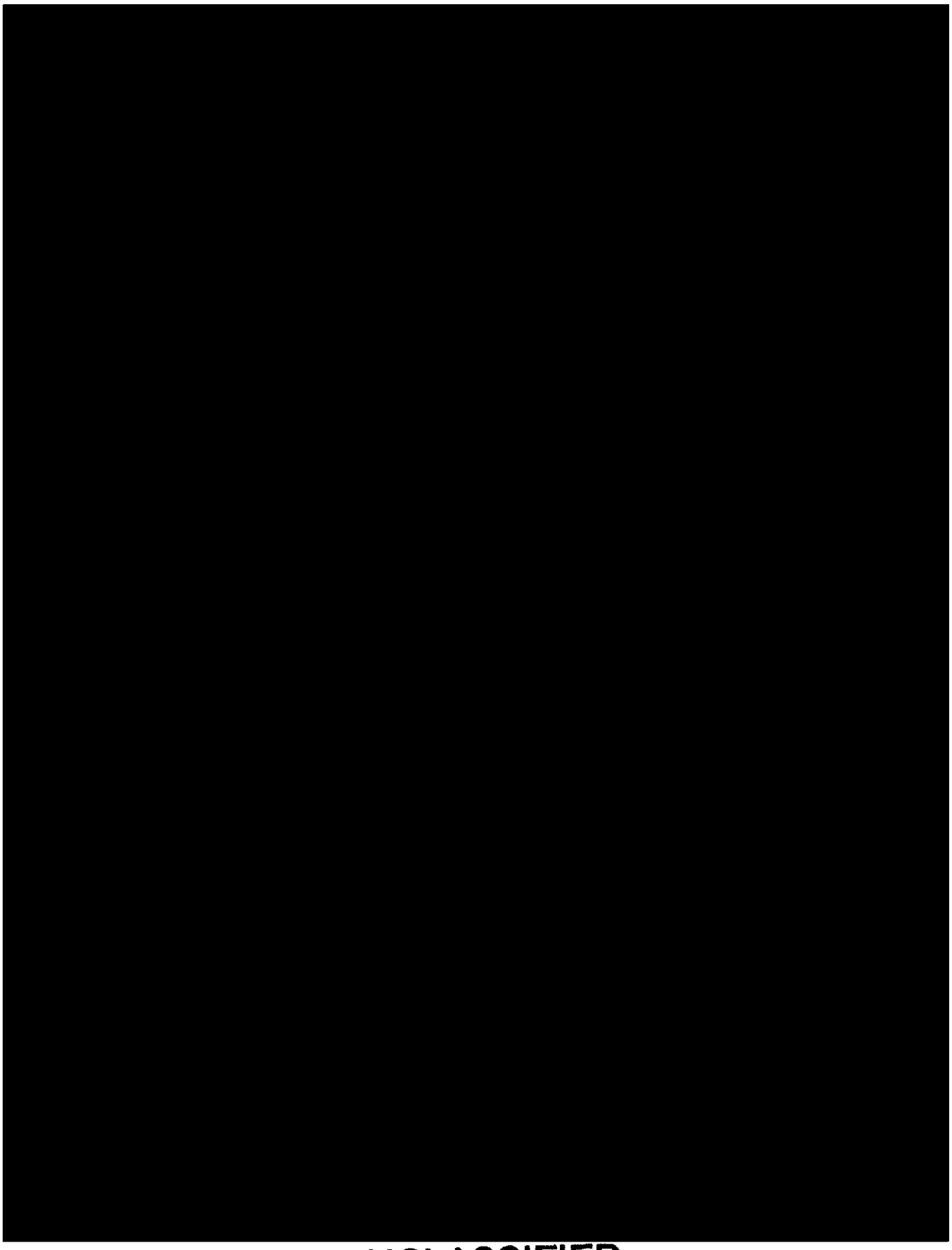

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Attachment P

FORENSIC PSYCHIATRY

[redacted]

DIPLOMATE IN PSYCHIATRY AND FORENSIC PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

April 21, 2005

[redacted]

Re: O.K.

Dear Professor [redacted]

You have asked me to provide you with assistance in evaluating O.K.'s mental health situation in view of his ongoing detention at the United States Naval Base, Guantanamo Bay, Cuba. You have expressed concern about his mental condition, yet you have been unable to secure an independent mental health evaluation. Because of this inability on your part and that of other counsel representing detainees, my colleagues and I at the University of Hawaii Forensic Psychiatry Program, with the assistance of [redacted] Ph.D., have developed an attorney/translator-administered questionnaire which we believe to be appropriate for the proxy assessment of individuals in confinement without access to mental health evaluation. My qualifications for conducting such an assessment are outlined in the enclosed c.v.

The findings presented below are derived from such administration of this questionnaire, interpreted by Dr. [redacted] and me. This is not, however, to be considered a substitute for a full psychiatric or psychological evaluation and the opinions are limited, as there was no personal examination of the detainee.

Findings and Opinions

Results of the Proxy Psychiatric Assessment indicate that O.K. is self-reporting symptoms that suggest he meets full criteria for a diagnosis of Post-Traumatic Stress Disorder. Specifically, he is indicating that he experienced an event that involved actual or threatened serious injury or a threat to the physical integrity of self, felt intense fear and helplessness, and since that event has persistently re-experienced intrusive distressing recollections of the event, recurrent distressing dreams, feeling as if the traumatic event were recurring, marked diminished interest in significant activities, inability to recall aspects of the trauma, difficulty in falling or staying asleep, irritability, difficulty concentrating, and hypervigilance. In addition, O.K. endorsed items that

suggested that he may be experiencing a Major Depressive Episode. Related symptoms include difficulty falling asleep and staying asleep, feeling hopeless about the future, a dysphoric mood, anhedonia, and suicidal ideation. O.K. did not endorse all possible symptoms, and his pattern of responding was not similar to that which is usually seen in a person who might be exaggerating their responses for secondary gain.

In more detailed questioning, O.K. reported being subjected to various types of physical torture and threats. The torture he reported included restriction from medical care, and water, not being allowed to use the bathroom, being forced into painful positions or suspensions, threatened with dog attacks, implied threats about sexual assault, beatings, and enforced isolation from others.

In my opinion O.K. is likely to suffer continuing and exacerbated symptoms if he is not removed from the stressors described.

Please let me know if you would like clarification of these findings.

Sincerely,

[redacted]

DECLARATION OF [redacted]

[redacted] hereby declare that to the best of my knowledge the following is true and correct:

1. I have personal knowledge of the matters stated herein and, if called upon to testify, could competently testify thereto.

2. My qualifications to render expert psychological opinions include my education and training and over thirty years of clinical, research, and programmatic experience as a child and adolescent psychologist, as set forth in detail in my *curriculum vitae*, which is attached hereto as Exhibit 1.

3. I received my Ph.D. in clinical and community psychology from the [redacted] My postgraduate training has included an internship in clinical psychology at the Univ[redacted]

4. I am currently [redacted] I direct the Division of Public Behavioral Health and Justice Policy. For twelve years, from 1987 to 2000, I was the Director of [redacted] and [redacted] I conduct research and publish on a wide range of issues related to juvenile and adult offenders.

5. I also currently direct the mental health clinics in both county and state juvenile facilities in [redacted] nder contract with the [redacted]

6. I also serve as an expert /consultant to the U.S. Department of Justice's Civil Rights Division's Special Litigation Section. I have and continue to be involved in the Department of Justice's investigations of conditions of confinement under the Civil Rights of Institutionalized Persons Act (CRIPA) in a number of states and counties. The subject of detainee isolation, seclusion and solitary confinement is often a focus of these investigations. In addition, I serve as the mental health monitor on a number of settlement and consent decrees.

7. Over the course of my career I have evaluated the mental health of hundreds of youth detained in correctional facilities.

8. I have been retained by [redacted]'s counsel, the [redacted] to conduct an evaluation of [redacted]'s current mental status. The assessment provided in this Declaration is based on representations made to me by one of [redacted]'s attorneys, [redacted]

9. According to Professor Ahmad, [redacted] is an adolescent of 17 years of age who has been detained at the U.S. Naval base at Guantánamo Bay, Cuba, since the age of 15. It is

believed that he has been held in solitary confinement since his capture and incarceration two and a half years ago. O.K. has not been permitted contact with his family, with other children his age, or with his attorneys.

10. It is believed that O. K. was shot three times at the age of 15, while still in Afghanistan, and that he is in poor physical health.

11. I understand that approximately 31 suicide attempts have been made by detainees at Guantánamo Bay.

12. Both my clinical experience and the research literature reflect the profound deleterious effects of extended isolation and solitary confinement on an individual's psychological functioning and overall health status (Bauer,M., Priebe ,S., et al,1993; Grassian, S., 1983; Haney,C. 2003; Jemelka,R., Trupin,E.,Chiles,J., 1989; Mitchell, J., Varley, C., 1990). Suicide attempts, self mutilation, auditory and visual hallucinations, paranoid delusions leading to violent aggressive behavior, memory and attentional problems, other cognitive dysfunctions and a wide range of physical problems stemming from eating and sleeping problems have been consistently identified in individuals subjected to relatively brief isolations (less than a week).

13. Standards of care and practice policies have been established to address the management of youth maintained in isolation and solitary confinement by the Office of Juvenile Justice and Delinquency Prevention, The National Council on Correctional Healthcare and the American Psychiatric Association. In the standards established by these entities, long term solitary confinement is not supported. When brief isolation or solitary confinement is deemed necessary for the security or safety of the youth or others due to specific manifestations of self harming or aggressive behaviors, delineated procedures related to mental health care are specified. These include regular assessment and evaluation from a qualified mental health professional and the initiation of treatment when deemed necessary by the mental health professional. The standards also require that correctional staff identify the specific behaviors a youth needs to display in order to be released from confinement and for how long they need to sustain this behavior.

14. The effects of persistent withholding of sensory, cognitive and emotional contact and stimulation can have a limiting and deviant effect on both behavior and neuropsychological development with adolescents. The capacity to be resilient to the effects of isolation is compromised by their inability to utilize the cognitive and emotional strategies that develop as a function of maturity. Without social contact or regular communication with family or adults who display concern for one's circumstances (even though they may be horrified by the adolescent's crime), adolescents display increasing manifestations of psychopathology.

15. In addition, the inability of the adolescent to display any behavior which could influence a change in the circumstances of their confinement often contributes to the exacerbation of symptoms such as self mutilation, depression and or aggressiveness. For these youth, the lack of any control over the circumstances of their confinement in

combination with the absence of social contact contributes to the persistence and exacerbation of psychiatric symptoms.

16. The conditions of [redacted]'s confinement may cause mental deterioration so severe as to impair [redacted]'s ability to understand the legal consequences of the charges made against him and to assist his attorneys in his defense. Moreover, these conditions make particularly susceptible to mental coercion and false confession.

17. The impact on an adolescent such as [redacted] who has been isolated for over two and a half years is potentially catastrophic to his future development. Long term consequences of extended confinement are both more pronounced for adolescents and more difficult to remediate or treat even after solitary confinement is discontinued. It is my opinion, to a reasonable scientific certainty, that [redacted]'s current conditions of confinement place him at significant risk for future psychiatric deterioration, which may include irreversible psychiatric symptoms and disorders.

18. In order to effectively address [redacted]'s mental status, his competency to understand the legal implications of the charges being brought and the impact of the conditions of confinement on his overall functioning, it will be necessary to conduct a comprehensive in person interview, assessment and record review estimated to take a minimum of three days.

19. I am qualified to perform such an evaluation on [redacted] and am willing and available to travel to Guantánamo Bay in order to do so.

20. In light of reports that [redacted] may suffer from ongoing physical injuries, it is advisable that a physician specializing in internal medicine evaluate [redacted] as well.

21. The opinions rendered in this Declaration were reached without conducting a personal examination of [redacted] due to government restrictions preventing access to him.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 5th day of August, 2004.

[redacted]

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The neurological consequences of explosives

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Abstract

Neurological injuries produced by explosive blasts are the result of a cascade of events that begin with the initial explosion and evolve from the secondary, tertiary, and quaternary effects that the explosion engenders [Lavonis EJ. Blast Injuries. EMedicine.htm]. Only the results of the primary blast are predictable, and subsequent actions ripple outward in an increasingly random and chance sequence. This article reviews and explains how the ensuing chain of circumstances injures the nervous system, and what examining physicians should anticipate when they treat these patients.

Keywords: Terrorism; Explosives; Blast injuries; Brain damage; Nervous system damage

1. Introduction

The rapid chemical conversion of a solid or liquid into a gas results in a release of energy that produces an explosion. Propellants, like gunpowder, are designed to release energy slowly, while high explosives are designed to detonate quickly [2]. High explosives are integral to the current weapons of choice for terrorists and are the subject of this paper.

For the purpose of terror, explosive devices can be divided into four main categories: those which are projected or propelled to the target, those which explode passively when the target sets off a trigger, those that sit passively until detonated by a combatant in a remote and secure location, and those that are deliberately designed, transported and detonated in a site that is chosen to produce the greatest degree of physiological and psychological trauma and terror.

The first category consists of bombs, missiles, and projectiles. The second group is made up of the traditional land mines and unexploded, but still "live", ordnance, which detonate only if the victim sets off the trigger. The third and fourth groups have evolved in modern insurgencies. Simple electronic technologies allow a terrorist to directly visualize a target and remotely detonate a passive explosive. Those who transport the weapons to the target site may detonate the fourth group and may be part of the actual weapon. Since the third and fourth groups are the preferred weapons of terrorists, these will often be designed to maximize injuries at the site of the explosions and to create psychological panic in the targeted society.

The chain of events that begin with the blast determines the neurological injuries that the victims receive. The initial blast occurrences proceed in a predictable manner, while later ones involve more random factors. Because actual patients will have multiple site and multi-organ injuries, treating professionals will be faced with multidimensional injuries [3]. In order to understand how the injuries occur, one must understand the cascade of blast-related events (Table 1).

2. The primary blast injuries

2.1. The physics

Conventional explosives generate a biphasic blast wave that spreads from its primary point source. This is described mathematically as a *Friedlander Wave Form* [4]. The first phase is a high-pressure *shock wave* of very brief duration, followed the second phase *blast wind*, or air in motion [5].

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Table 1
Classifying blast injuries by mechanism of injury [1]

1. Primary injuries are caused by the blast wave generated by the explosion.
2. Secondary injuries are caused when objects that are set in motion by the blast strike the victim.
3. Tertiary injuries occur when the victim is blown against other moving or stationary objects by the force of the blast.
4. Quaternary injuries are the result of the effects of smoke, environmental debris, delayed onset of infection, collapsing buildings, and other environmental considerations [1].

These blast winds are often referred to metaphorically as "The Winds of War." The expression arose during the US Civil War, when observers noted men who were dead on the battlefield, with no visible wounds.

The size of the explosive, the rapidity of the conversion from gas to solid state, and whether or not the blast occurs in the open air or in an enclosed space will determine the initial characteristics of the blast wave [2]. Such blast waves are potentially more damaging when they occur under water, since water is denser than air [6]. Because terrorist explosions are virtually always air blasts, this paper will be limited to the consequences of blasts in that medium.

2.2. The mechanics

Injuries caused by the initial blast are the direct result of blast overpressure on tissue. This outcome differs between solid organs and those that are hollow and air filled. Air is more compressible than water, so air-filled structures, like the lungs, gastrointestinal tract and middle ear, are affected by this shock wave and blast wind combination.

Proximity to the site of the detonation is paramount. The intensity of the explosive pressure wave declines with the cube root of the distance from the detonation. Therefore, someone 5 m from the blast site will receive nine times more overpressure than someone at 10 m. For explosives containing 1–20 kg of TNT, people greater than 6 m from the blast site do not experience substantial primary blast injuries [7]. The effectiveness of these smaller explosives is magnified by detonation within a closed space, within a corridor that will focus the blast effects, or by including objects designed to become secondary projectiles. Because blast waves are reflected by and reverberate against solid surfaces, someone next to a wall will have increased primary blast injuries because of the enhanced pressure differences and the production of standing waves [8].

Enhanced-blast explosive devices disseminate the explosive first and then trigger it, causing secondary explosions that increase the area from which the high-pressure wave radiates, prolong the duration of the overpressurization phase, and increase the total energy transmitted by the explosion [5].

Explosions that occur in water or enclosed spaces, such as buildings or lightly constructed vehicles, will cause more serious injuries. Mortality from primary blast injuries in closed spaces can increase by over 100% compared to the results of detonations in open spaces [9].

2.3. The consequences

Primary blast injuries are caused by barotrauma—either overpressurization or underpressurization relative to atmospheric pressure. Primary blast injuries most commonly involve air-filled organs and air–fluid interfaces. Body armor does not protect against the barotraumas of primary blast injury [10]. Organs are damaged by dynamic pressure changes at tissue-density (air–fluid) interfaces due to the interaction of a high-frequency stress wave and a lower frequency shear wave [5,11] (Table 2).

Pulmonary barotrauma is the most fatal primary blast injury. Pressure differentials across the alveolar–capillary interface cause disruption, hemorrhage, pulmonary contusion (appearing as a bihilar "butterfly" pattern on chest radiographs), pneumothorax, hemothorax, pneumomediastinum, and subcutaneous emphysema [12–14]. The immediate onset of pulmonary edema with frothing at the mouth (associated with bilateral radiographic "whiteout") carries a grave prognosis [5]. These injuries can lead to systemic air embolism with ischemic results, hypoxia due to the inability of the lung to exchange gases, and free radical-associated injuries such as thrombosis, lipoxygenation, and disseminated intravascular coagulation.

Primary blast injuries to the brain and spinal cord include blast wave-induced concussion as well as barotrauma caused by acute gas embolism. Air embolism can produce ischemia and infarction of the brain and spinal cord [5]. Loss of consciousness and coup/contrecoup injuries formerly were considered secondary or tertiary injuries, but with the increased use of body armor in the military, damage to the central nervous system after an explosion has been increasingly attributed to the direct effects of the blast [5,15,16].

Tympanic membrane rupture, hemotympanum, and dislocation or fracture of ossicles occurs at this phase. The tympanic membrane is the structure injured most frequently, and at the lowest pressure of all the organs, by the primary blast effects. The eardrum thus represents a site for detecting primary effects of blasts [12]. An increase in pressure of as little as 5 psi above atmospheric pressure (1 atm is equivalent to 14.7 psi, or 760 mm Hg) can rupture the human eardrum [17]. Temporary neurapraxia in the receptor organs of the ear, manifested by deafness, tinnitus, and vertigo, characterizes rupture of the eardrum, which should be suspected

Table 2
Organs affected by primary blast effects [5,11]

1. Lungs–blast lung.
2. Tympanic membranes rupture.
3. Blast wave-induced concussion/contusion of the central nervous system.
4. Air embolism in blast lung with cerebral infarction.
5. Blast wave-induced ocular injuries [5,11].

even when the tympanic membrane cannot be seen after a blast incident. If dynamic overpressures are high enough, the ossicles of the middle ear can be dislocated. Traumatic disruption of the oval or round window can cause permanent hearing loss. In contrast, pressure gradients of 56 to 76 psi (3.8 to 5.2 atm) are needed to cause damage to other organs [18]. If there is no rupture of the tympanic membrane, then primary effects of blasts on other air-containing organs is unlikely [5].

Primary blast injuries to the eye include rupture of the globe, serous retinitis, and hyphema [5].

2.4. The secondary blast injuries

The primary blast wave propels objects into people. Depending on where these projectiles strike the individual, any part of the nervous system can be affected in an immediate and delayed fashion. Some of the fragments occur due to damage to structures at the blast site, while others are produced intrinsically by the design of the weapon. These produce blunt and penetrating type injuries [5]. Proximity to the primary explosive site, interposing structures, and chance determine what parts of the nervous system are injured.

3. The tertiary blast injuries

High-energy explosions produce these injuries by propelling the individual through space and into other objects. Any part of the nervous system can be affected, both immediately and in delayed fashion, depending on the speed of the projection, the forces generated by the sudden deceleration, and how the body hits other projected and fixed objects. Usually the individual who sustains tertiary blast injuries is close to the site of the explosion, or is small in body mass, or the explosion is focused through a narrow opening. Children are especially vulnerable [18]. These injuries include skull fractures, open and closed head and spinal cord trauma, cerebral evisceration in children, contusions and concussion of nervous tissue, and peripheral nerve injuries due to traumatic limb amputations or the ischemia produced by edema associated with crush injury-induced compartment syndromes. The characteristic sign of the compartment syndrome is pain out of proportion to the injury. Mortality in those whose rescue is delayed by rubble and other hindrances to access is directly influenced by the sequelae of crush and compartment injuries [5].

4. The quaternary blast injuries

These are the most random. These involve injuries caused by circumstances such as the collapse of structures onto the person, the effects of toxic and noxious materials that are released, and the effects of fire. These include radiation exposure, chemical and thermal burns, toxic inhalation and exposure, hypoxia and asphyxiation from fire, poisoning by carbon monoxide and/or cyanide from incomplete combustion, and inhalation of aerosolized pollutants such as coal dust and asbestos. Additional crush injuries occur with collapse or displacement of structures and heavy objects. Vehicles are required to concentrate even high-performance explosives in amounts need to produce explosions of sufficient magnitude to collapse a building [19,20].

5. The evolution of the neurological disorders caused by explosives

The immediate injuries relate to the effects of baropressure, blunt and penetrating trauma, hypoxia and ischemia, severance and evulsions of nerve roots, plexuses, and peripheral nerves, and contusion, concussion and evisceration of nervous tissues. These manifest clinically as pain, altered consciousness, cognitive impairment, loss of function, and epilepsy. As much as possible, these are attended to during the initial phases of treatment, but some are not obvious until the patient regains consciousness and cognition.

Traumatic brain injury caused by passively and remotely detonated explosives accounts for a larger proportion of military casualties than in other wars [21]. Soldiers protected by body armor have fewer penetrating injuries of the nervous system, as compared to the civilians and those caught without protection. The severity of their wounds will differ. Injuries occur through gaps in the armor. The extent of secondary, tertiary, and quaternary injuries depends on whether the victims were in an open space, in a closed vehicle, in a building that collapses, or exposed to toxic agents. Late effects include PTSD, mood, anxiety, and panic disorders, epilepsy, and infections with antibiotic resistant bacteria that are peculiar to certain geographic locations. Multiple antibiotic-resistant *Acinetobacter baumanii* infections are described as an epidemic among individuals wounded in Iraq, as compared to Afghanistan [22]. One fatal case of *A. baumanii* meningitis has been reported in the media [23].

Different syndromes are identified as the effects of the primary trauma-hemorrhage, edema, and tissue disruption. Dyspraxia, dysphasia, executive dysfunctions, paralysis, deficits and dysfunctions of special senses, and mood disorders emerge and evolve as awareness improves, and as the nervous system attempts to function based on its premorbid connections and abilities.

Physicians at Walter Reed Army Medical Center categorize the severity of traumatic brain injury (TBI) according to the duration of loss of consciousness and post-traumatic amnesia. Mild TBI is defined as an injury that causes loss of consciousness for less than 1 h or amnesia lasting less than 24 h. Moderate TBI produces loss of consciousness lasting between 1 and 24 h or post-traumatic amnesia for 1 to 7 days. Severe TBI causes loss of consciousness for more than 24 h or post-traumatic amnesia for more than 1 week. Patients with mild TBI usually do not have visible abnormalities on brain imaging, while moderate

or severe TBI patients may have punctuate hemorrhages in the corpus callosum and other regions, as well as evidence of bleeding or swelling [21].

Susan Okey summarizes the symptoms of the patients and the findings of the staff as follows: "Soldiers with TBI often have symptoms and findings affecting several areas of brain function. Headaches, sleep disturbances, and sensitivity to light and noise are common symptoms. Cognitive changes, diagnosed on mental-status examination or through neuropsychological testing, may include disturbances in attention, memory, or language, as well as delayed reaction time during problem solving. Often, the most troubling symptoms are behavioral ones: mood changes, depression, anxiety, impulsiveness, emotional outbursts, or inappropriate laughter. Some symptoms of TBI overlap with those of post-traumatic stress disorder…(pp. 2045–2046.)" [21] Other authors note the differences between veterans with post-traumatic stress disorder (PTSD) depending on whether or not they experienced blast injuries [15].

Multiple injuries complicate recovery because of the concurrence of cognitive, affective, attention, memory, and special sensory deficits. If symptomatic epilepsy develops, medication side effects play a role, as do the side effects medications for sleep, pain, and affective disorders. The stability of the injured individual's social network also influences the time to maximum medical improvement and the degree of recovery. Because the wounds often involve penetration of the body by dirty fragments of foreign material as well as body parts, years of infections and surgical revisions can occur, with evolution of psychosocial and affective problems, as well as known conditions like phantom pains.

The delayed psychological repercussions of terrorist acts to individuals and to a society–those that are due to pure terror–are difficult to measure and to quantify. These effects can linger for a lifetime.

6. Treatment and management strategies

The initial strategies for response involve two triage teams, one on site, and one at the hospitals to which survivors are sent. Victims who are not breathing at the site, who have 100% body burns, or who have fixed and dilated pupils, do not survive, and resuscitation is discouraged. The walking wounded will take themselves for attention, and this is where the secondary triage assures that the most severely wounded, who usually arrive later from the scene, receive the more critical immediate hospital attention before those who arrive injured, but awake and ambulatory [2,5,7,9,10,24–26].

The direct injuries to brain, spinal cord, nerve plexi, and peripheral nerves are initially treated in standard fashion. Because debris from the blast will continue to be present, sequential surgeries should be expected in order to deal with the problems they produce [5]. Practitioners at the US Veterans Administration and the US Department of Defense stress the need for a rehabilitation-focused blast injury program and for optimization of care for combat amputees. Their models are described in three recent publications [27–29]. Medications for treatment of epilepsy and headaches will vary depending on availability in the home country. Medicines with fewer cognitive side effects will be preferred over the older ones that can compound problems already caused by blast injuries.

The neuropsychiatric sequelae of traumatic brain injury are more diverse (Table 3) [30]. Evaluation of traumatic brain injury involves four steps (Table 4). The *Trajectory of Recovery* can continue for several years, and treatment of the delayed neurobehavioral sequelae can last for the patient's lifetime [27]. Medications should be chosen to minimize cognitive and somatic side effects, to the degree that a wider choice of medicines is available in the home country.

There are also a series of neurobehavioral sequelae that can be delayed in onset. The treating staff must be aware of these and anticipate their emergence. Mood disorders, epilepsy, and de novo memory deficits can arise within the

Table 4
Prediction of outcome [29]

1. The Rule of Severity: the extent and degree of the cerebral insult, based on actual brain damage and length and depth of coma.
2. The Rule of Nonspecificity: the extent to which elements external to the injury itself, such as age, sex, laterality, sex, genetic proclivities, and other factors, influence the effects of the location and extent of the lesion. This influences the overt physical and neurological consequences of the injury.
3. The Law of Reserve: the extent of premorbid resources such as intelligence, mental stability and family support. This determines the premorbid level of function, the psychological reserve, and the individual areas of premorbid weakness.
4. The Post Treatment Environment: this can promote stability and recovery, or instability and deterioration [29].

Table 3
Neuropsychiatric sequelae of traumatic brain injury [29]

1. The Postconcussion Syndrome
2. Personality changes
3. Posttraumatic headache
4. Frontal lobe syndromes: convexity lesions; orbitofrontal lesions
5. Temporal lobe syndromes: memory impairments; affective disorders; psychoses; interictal personality disorders in epileptics
6. Thalamic Syndromes
7. Agitation during coma recovery [29]

Table 5
Delayed neurobehavioral sequelae of traumatic brain injury [30]

1. Affective disorders, especially depression, occur in the first 1 or 2 years after the injury.
2. Memory deficits may arise de novo after 2 years.
3. Posttraumatic epilepsy.
4. Posttraumatic psychosis, which occurs at a similar frequency as posttraumatic epilepsy, can occur within the first 10 years after the injury.
5. Dementia, which can evolve over the remainder of the individual's lifetime [30].

first two years, while psychosis can emerge up to ten years after the injury, and dementia even later during the rest of the individual's life [31]. (Table 5).

The World Health Organization (WHO) stresses that the barriers to participation in communities originate primarily from social and cultural attitudes, rather than from the impairments of the injuries. The WHO emphasizes "demedicalising" disability, in favor of an approach that works more closely with the family through community based rehabilitation projects [32,33]. Because poverty and disability are inextricably linked, community participation is a vital part of social and economic regeneration, equality, and human rights [33].

Acknowledgments

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Attachment U

[redacted]

From: jeffredg [jeffredg@ptf.gov]
Sent: [redacted]

Subject: RE: D064 - U.S. v. Khadr - Affidavit in Support of Def Mot for Appropriate Relief - Experts [redacted]

Attachments: U.S. v. Khadr - Order - 706 Board.doc

U.S. v. Khadr - Order - 706 Bo...

Gentlemen,

Please pass to Colonel Parrish.

Sir,

In light of the assertions raised by the Defense in the subject motion, the Prosecution respectfully requests the Military Judge sign the attached order, directing an inquiry under RMC 706 into the mental capacity and mental responsibility of the accused.

V/R,

Jeff Groharing

[redacted]

-----O[redacted]

LTC[redacted] & Ms. [redacted],

An affidavit in support of D064, the defense motion requesting appointment of BG[redacted] (Ret'd) and Dr. Porterfield as expert witnesses and consultants for Mr. Khadr, i[redacted]ed for filing with the Commission.

V/r
Ms. Snyder

Rebecca S. Snyder
Attorney
Office of Military Commissions
nsel
[redacted]

UNITED STATES OF AMERICA v. OMAR AHMED KHADR	**Defense Response** To Government Request for Inquiry into the Mental Condition of the Accused 1 July 2008

1. **Timeliness:** This response is filed within the timeframe established by the Military Judge's e-mail order of 26 June 2008.

2. **Relief Sought:** The defense respectfully requests that this Military Commission deny the prosecution's request for an inquiry into the mental condition of the accused.

3. **Overview:** In D-064, the defense moved this Military Commission for an order appointing Drs. [redacted] and [redacted] as members of the defense team. Rather than respond to the defense motion, the prosecution has elected to ask the Military Commission to order an inquiry into Mr. Khadr's mental condition pursuant to R.M.C. 706. The fact that the prosecution has so moved, should be viewed as an unambiguous concession that Mr. Khadr's age and circumstances of confinement necessarily raise mental health questions requiring investigation and analysis. But the inquiry contemplated by the prosecution request (and by R.M.C. 706) is wholly inappropriate in light of the unique considerations raised by Mr. Khadr's age at the time of his initial detention and throughout most of his subsequent confinement as well as the conditions of that confinement. Moreover, an R.M.C. 706 inquiry will likely prove counterproductive (and possibly fatal) to defense efforts to maintain an effective attorney-client relationship with Mr. Khadr. This task has been made extraordinarily difficult as a result of Mr. Khadr's treatment while confined, which has created still insurmountable barriers to defense counsels' ability to obtain information from Mr. Khadr needed to prepare his defense. . Accordingly, the prosecution request should be denied. The Military Commission should deem the prosecution's failure to respond to D-064 as a waiver of its right to oppose the defense motion and order the relief requested therein.

4. **Response:**

a. The defense need for the expert services of Drs. [redacted] is broader than the need to answer the questions addressed by an R.M.C. 706 inquiry. While examination and evaluation by the requested experts will lead to the development of evidence regarding Mr. Khadr's capacity, or lack thereof, to stand trial or mental responsibility, or lack thereof, at the time of the alleged offenses, their services will assist the defense in a variety of other matters relating to trial preparation. These include assisting Mr. Khadr in discussing certain aspects of his detention and treatment that he has thus far been unable to discuss with defense counsel because of the psychological trauma involved in recounting these matters. In addition, because of their training and experience in working with victims of torture and abuse, Drs. [redacted] will be able to provide a basis for corroboration of claims of abuse

and maltreatment and thereby provide evidence that is critical to resolution of key factual issues at trial and in connection with anticipated motions to suppress (i.e., whether Mr. Khadr's statements are reliable). Finally, [redacted] and [redacted] will provide a foundation of information concerning Mr. Khadr that will be drawn upon by other defense experts, such as Dr. [redacted] (an expert in the reliability of juvenile interrogation and confession already approved by the Convening Authority), and a potential defense expert on the subject of mitigation in light of Mr. Khadr's age and upbringing before his detention by U.S. authorities. Accordingly, an R.M.C. 706 inquiry simply does not "answer the mail" in responding to the basis for the defense motion for Drs. [redacted]

b. Second, even if the limited inquiry contemplated by R.M.C. 706 was all that was at issue, the procedure proposed by the prosecution would not only be wholly inappropriate in light of Mr. Khadr's unique circumstances, it would be destructive to the defense ability to maintain a relationship with Mr. Khadr and effectively prepare a defense. Fifteen at the time of his initial shooting and detention by U.S. authorities, Mr. Khadr was a juvenile during the most critical period of his detention and interrogation by U.S. authorities. As a juvenile, his case presents a range of unique issues requiring the specialized attention of a psychologist and a psychiatrist trained in the evaluation and treatment of juvenile (or pediatric) detainees. Such was recognized by the U.S. government's own experts in formulating the "Recommended Course of Action for Reception and Detention of Individuals Under 18 Years of Age" at JTF-GTMO. (*See* Attachment D to Def. Mot. to Suppress, D-061.) Examination and evaluation by government personnel who lack the training and expertise of Drs. [redacted] could undo months of defense counsels' efforts at rapport building with Mr. Khadr and critically impair defense counsels' ability to work with their client in preparing for trial. This is particularly true in light the information contained in the classified portions of the requests for Drs. [redacted] and [redacted] filed with the Commission in support of D064. *See* Classified Defense Request for Appointment of Expert Consultant Dr. [redacted] to the Defense Team, para. 4(a)(iii) and documents cited therein; Classified Defense Request for Appointment of Expert Consultant Brigadier General [redacted], M.D. (Ret.) to the Defense Team, para. 4(a)(iii) and documents cited therein. Mr. Khadr is aware of the information contained in paragraphs 4(a)(iii) of those requests fact and, as a result, has developed a strong distrust of such government personnel. Furthermore, although the government may have psychologists and/or psychiatrists trained in dealing with children, they are extremely unlikely to have the qualifications and experience of Drs. [redacted], particularly their expertise in dealing with victims of torture and abuse. Thus, there is simply no substitute for the experts requested by the defense.

c. Third, the government's request for an R.C.M. 706 analysis is a concession that there are mental health questions that require investigation and analysis. The prosecution's failure to respond to the defense motion to appoint Drs. [redacted] should be construed as a waiver of any objection to the requested relief. The very need to litigate what doctors with which types of expertise are required to evaluate the unique issues presented by Mr. Khadr's age at the time of the alleged conduct and during his confinement highlights the fact that the rules governing this Military Commission were never intended to, and are incapable of adequately dealing with, the issues unique to juvenile justice. However, in light of the

Commission's previous ruling on D-022 (Def. Mot. to Dismiss (Child Soldier)), the path forward at this point is to deny the prosecution request and grant D-064.

William Kuebler
LCDR, USN
Detailed Defense Counsel

Rebecca S. Snyder
Assistant Detailed Defense Counsel

UNITED STATES OF AMERICA	)	**Order**
	)	
	)	
v.	)	
	)	**14 August 2008**
OMAR AHMED KHADR	)	
a/k/a "Akhbar Farhad"	)	
a/k/a "Akhbar Farnad"	)	
a/k/a "Ahmed Muhammed Khali"	)	

1. This Order is issued pursuant to the authority under the Military Commissions Act (MCA) of 2006 (10 U.S.C. §§ 948a, *et seq.*) and the Manual for Military Commissions (MMC), to include but not limited to:

a. Rule for Military Commissions (RMC) 706;
b. RMC 909;
c. RMC 916.

2. In light of the issues raised by Defense Counsel in D064 (see enclosure), I have determined that it is appropriate to order an inquiry into the mental capacity and mental responsibility of the accused prior to proceeding to trial. The charge sheet is enclosed.

3. Accordingly, IT IS HEREBY ORDERED:

a. THAT the accused be examined by a Medical Board consisting of one or more physicians or clinical psychologists, at least one of whom should be a psychiatrist or a clinical psychologist, as provided by Rule for Military Commissions 706, Manual for Military Commissions, 2007. The report shall be completed no later than 10 September 2008 unless the Military Judge grants a request for an extension based upon good cause shown.

b. THAT all existing medical or mental health records currently maintained by any individual or institution within the control of the U.S. Government be released to the Medical Board for review.

c. THAT the board shall make separate and distinct findings as to each of the following questions:

(1) At the time of the alleged criminal conduct, did the accused have a severe mental disease or defect? (The term "severe mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, or minor disorders such as nonpsychotic behavior disorders and personality defects.)

(2) What is the clinical psychiatric diagnosis?

(3) Was the accused, at the time of the alleged criminal conduct and as a result of such severe mental disease or defect, unable to appreciate the nature and quality or wrongfulness of his conduct?

(4) Is the accused presently suffering from a mental disease or defect rendering the accused unable to understand the nature of the proceeding against the accused or to conduct or cooperate intelligently in the defense?

d. THAT upon completion of the board's investigation, a statement consisting of only the board's ultimate conclusions as to all questions specified in the order shall be submitted to the Commander, Joint Task Force Guantanamo Bay, and to all counsel in the case, the convening authority, and to the Military Judge; and

e. THAT the full report of the board may be released by the board or the medical personnel only to other medical personnel for medical purposes, unless otherwise authorized by the Military Judge, except that a copy of the full report shall be furnished to the Defense and, upon request to the Commander, Joint Task Force Guantanamo Bay; and

f. THAT neither the contents of the full report nor any matter considered by the board during its investigation shall be released by the board or other medical personnel to any person not authorized to receive the full report, except pursuant to an order by the Military Judge.

4. Any breach of this Order may result in disciplinary action or other sanctions.

encl
as

Patrick J. Parrish
Colonel, JA
Military Judge

UNITED STATES OF AMERICA	)	**ORDER**
	)	
	)	**Defense Motion for**
v.	)	**Appropriate Relief**
	)	**D064**
	)	
OMAR AHMED KHADR	)	Request for Appointment of
a/k/a "Akhbar Farhad"	)	Certain Expert Consultants
a/k/a "Akhbar Farnad"	)	and Witnesses
a/k/a "Ahmed Muhammed Khali"	)	

1. The Defense requests the Commission to order the appointment of Brigadier General (BG) [redacted] M.D. (retired) to work as an expert consultant and witness in the field of developmental psychiatry (child and adolescent) and [redacted] to work as an expert consultant and witness in the field of clinical psychology who also has expertise in trauma and torture. The Government opposes this request.

2. Mr. Khadr was an adolescent at the time of the alleged offenses. The Commission finds that expert assistance in the form of developmental psychiatry or clinical psychology would be beneficial to the Defense in preparation of its case on the merits and or sentencing, if the case reaches the sentencing stage. The Commission is mindful that the Defense has already received expert assistance in the form of a psychiatrist. In light of this, the Commission finds that the Defense has not shown that both an additional psychiatrist and a clinical psychologist are necessary. Accordingly, the request is granted in part and denied in part.

3. The Government will appoint an expert who is comparably qualified as the requested expert in the field of developmental psychiatry, or an expert who is comparably qualified as the requested expert in the field of clinical psychology to work for the Defense. If the Government is unable to find such a comparably qualified expert, the Government will appoint either BG (R) [redacted] to work for the Defense. Any such expert appointed to work for the Defense will be a member of the Defense team.

4. The Government will comply with this order no later than 27 August 2008.

So Ordered this 14th day of August 2008.

Patrick J. Parrish
COL, JA
Military Judge